

2182

CERTIFICATE OF DEATH

02109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gelia Middle B. Last Allen		4. DATE OF DEATH Month Feb. Day 23 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1874
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Attendance Officer		11. BIRTHPLACE (State or foreign country) Winchester, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel House		14. MOTHER'S MAIDEN NAME Cecelia C. Belts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Fred Eberz-		Address 8604 Garfield Street Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 16, 1959 to Feb-23, 1960 that I last saw the deceased alive on February 17, 1960 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Wannascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 2/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington 9, D.C.	
24a. REC'D BY REGISTRAR FEB 24 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1943

ESTIMATE OF DATA

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

1943 - Annual Report, 1943

2183 CERTIFICATE OF DEATH

02110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 36 days				d. STREET ADDRESS 5510 First Street, N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bernard Wilson Anthony, Jr.				4. DATE OF DEATH Month Day Year February 17 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 27, 1959		9. AGE (In years lost birthday) yrs. 2	10. IF UNDER 1 YEAR 2 Months 20 Days 0 Hours 0 Min.
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard W. Anthony				14. MOTHER'S MAIDEN NAME Gloria Herron			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 769.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Toxoplasmosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Birth
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 12, 1960 , to February 17, 1960 , that I last saw the deceased alive on February 17, 1960 , and that death occurred at 7:50a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard M. Kravitz				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-17-60			
PHYSICIAN'S NAME (Type) HOWARD M. KRAVITZ, M.D.				NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Bethesda Cemetery		22d. LOCATION (City, town, or county) (State) Bethesda, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edna J. Adams				24a. READ BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Director of the Bureau

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02111

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				d. STREET ADDRESS <u>3971 Wendy Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3971 Wendy Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Edward Atkinson</u>				4. DATE OF DEATH <u>Feb 28</u> 19 <u>60</u>		5. AGE (In years last birthday) <u>69</u> yrs.	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1890</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if specialized) <u>Asst Supt. Tooling Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Atkinson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ellis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>10-11-1890</u>		17. INFORMANT <u>Margaret Atkinson (wife)</u> Address <u>Thru 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c) <u>sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>sudden</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Math</u>	
23. FUNERAL DIRECTOR <u>W. J. Luntzmann & Son</u>				24a. REC'D BY REGISTRAR <u>Mar 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2184

CERTIFICATE OF DEATH

02112

Reg. Dist. No. 215

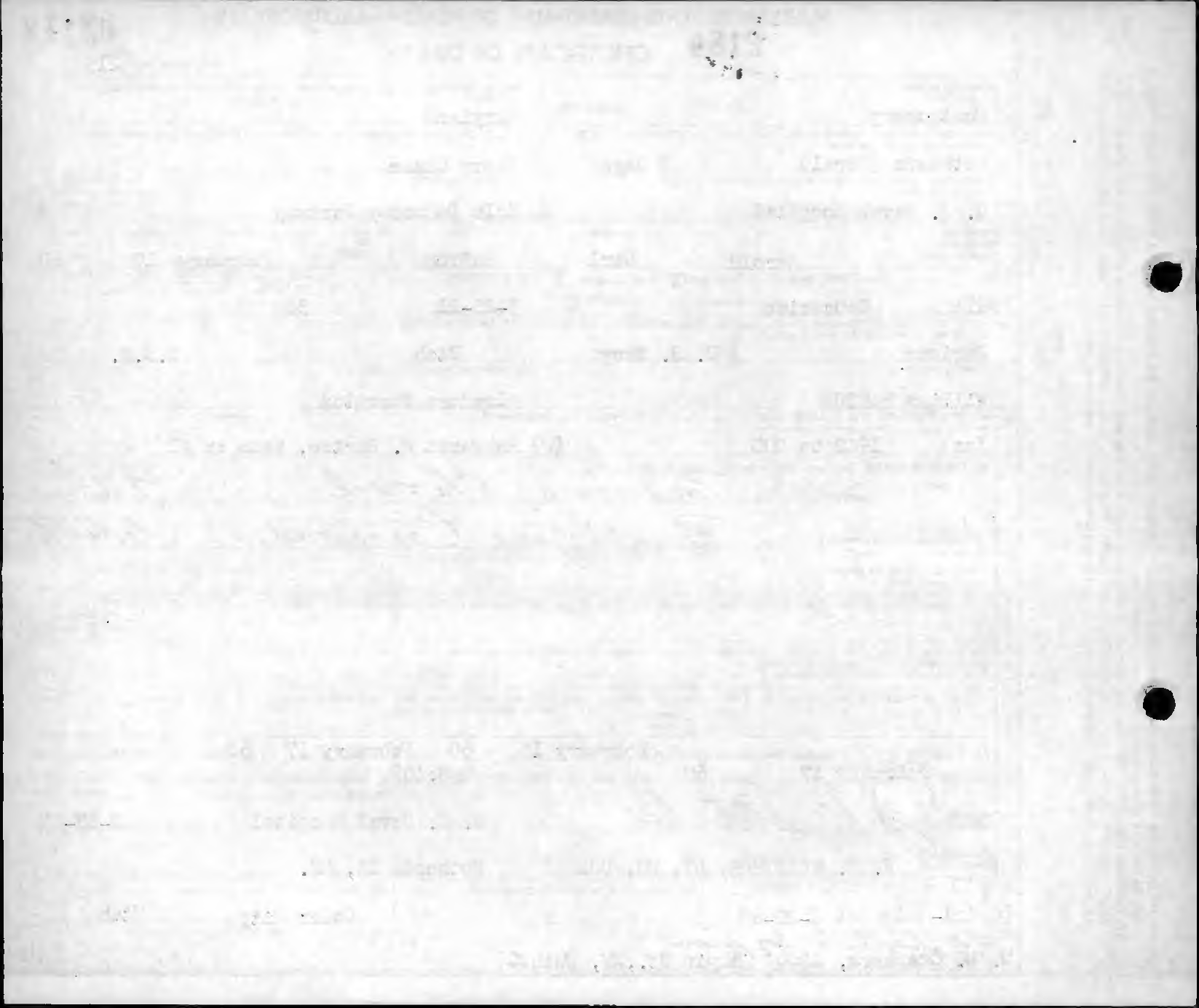
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
f. STREET ADDRESS <u>4616 DeRussey Parkway</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Carl</u> Last <u>BARTON</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-21</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William BARTON</u>				14. MOTHER'S MAIDEN NAME <u>Isadore Thornton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>1940 to DOD</u>			
17. INFORMANT <u>(W) Margaret M. Barton, same as #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 15, 19 60</u> to <u>February 17, 19 60</u> that I last saw the deceased alive on <u>February 17, 19 60</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. E. Stitcher</u>				ADDRESS (Street, city or town, state) <u>U. S. Naval Hospital</u>			
PHYSICIAN'S NAME (Type) <u>J. E. STITCHER, LT. MC, USN</u>				DATE SIGNED <u>2-18-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment 2-20-60</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>W. W. Chambers, 1400 Chapin St., NW, WashDC</u>				22d. LOCATION (City, town, or county) (State) <u>Cedar City Utah</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers by Sison</u>				ADDRESS <u>W. W. Chambers, 1400 Chapin St., NW, WashDC</u>			
24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Robert S. Thompson</u>			

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2185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bethesda Suburban Hospital				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Elizabeth Last Belt				4. DATE OF DEATH Month Feb Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/02X 01	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME David B. GOTTWALS				14. MOTHER'S MAIDEN NAME Edith Hunt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT M. BELT Address Husband M r. Alvin Same as Above.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Congestive heart failure DUE TO Myocardial hyper trophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cystic Nephrosis + Ch. pyelonephritis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jul 5 , 19 60 , to 11 Jul , 19 60 , that I last saw the deceased alive on 10 Jul , 19 60 , and that death occurred at L.A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave 17000 Kensington, MD DATE SIGNED 10/11/60							
ACTUAL SIGNATURE Horace W. Bernton M.D.							
PHYSICIAN'S NAME (Type) Horace Bernton							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2/13/60		22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY	
22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Jaska				24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE BANK OF ENGLAND

THE BANK OF AMERICA

THE BANK OF CALIFORNIA

THE BANK OF NEW YORK

THE BANK OF MONTREAL

THE BANK OF MEXICO

THE BANK OF PANAMA

THE BANK OF PERU

THE BANK OF PORTUGAL

THE BANK OF SPAIN

THE BANK OF SWITZERLAND

THE BANK OF THE NETHERLANDS

THE BANK OF THE UNITED STATES

THE BANK OF THE VENEZUELA

THE BANK OF THE WEST INDIES

THE BANK OF THE YAMEN

THE BANK OF THE ZAMBIA

THE BANK OF THE ZIMBABWE

THE BANK OF THE ZULU

THE BANK OF THE ZULU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2135

CERTIFICATE OF DEATH

Reg. Dist. No.

02114

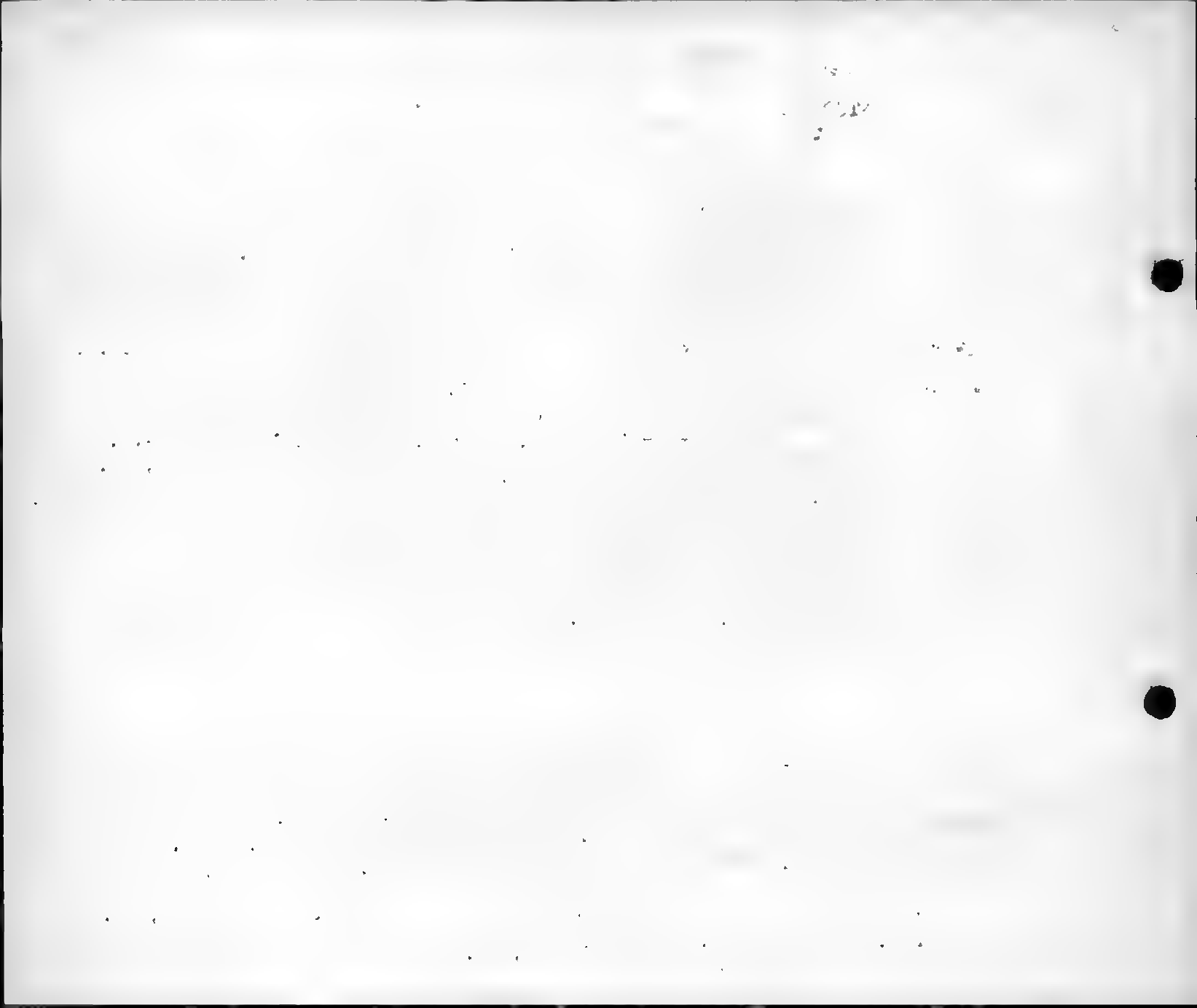
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		d. STREET ADDRESS <u>10001 Raymon Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE BINDES BERMAN</u>		4. DATE OF DEATH Month Day Year <u>February 7 1960</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Dykstein</u>		14. MOTHER'S MAIDEN NAME <u>(etc)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Jack Ager</u>		Address <u>10001 Raymon Rd SS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>32 hours</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 21, 1957</u> to <u>February 7, 1960</u> , that I last saw the deceased alive on <u>January 7, 1960</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9210 Colesville Rd, Silver Spring, Md. 2/5/60</u>	
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M. D.</u>		22. LOCATION (City, town, or county) (State) <u>9210 Colesville Road, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langensky</u>		ADDRESS <u>3501-14 St. N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	



2117 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2221 LUZERNE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BELMA BLANCHARD		4. DATE OF DEATH Month FEB. Day 6 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/05
9. AGE (In years lost birthday) 54 yrs		10. IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.	11. IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MILTON SMITH		14. MOTHER'S MAIDEN NAME SARA DANIELS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 237-14-1394	
17. INFORMANT Mrs. James L. Cambas, 2221 Luzerne Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO (b) 1 day Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/1/59 19 to 2/6/59 19, that I last saw the deceased alive on 2/6/59 19, and that death occurred at 6 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md. DATE SIGNED 2/6/60			
ACTUAL SIGNATURE John J. Curry M.D.			
PHYSICIAN'S NAME (Type) JOHN J. CURRY			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 2/9/60			
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. ADDRESS SILVER SPRING, MD.			
24a. REC'D BY REGISTRAR FEB 9 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



2186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>13 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5901 Lone Oak Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rolland E. Blosser</u>				4. DATE OF DEATH Month Day Year <u>February 16 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1887</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newcomb Standard, Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Isaiah Blosser</u>				14. MOTHER'S MAIDEN NAME <u>Martha Whitcraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WW#1</u>				16. SOCIAL SECURITY NO. <u>none</u>			
INFORMANT Address <u>Bethesda, Md</u>				17. INFORMANT <u>Josephine Blosser-5901 Lone Oak Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 151X DUE TO						<u>24 hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>anemia from inanition</u> <u>Several wks</u>	
(c) <u>Carcinoma Stomach & metastases</u> <u>18 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 1959</u> to <u>Feb. 16, 1960</u> , that I last saw the deceased alive on <u>Feb. 15, 1960</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Margaret E. Callan</u>				M.D. <u>4700 Bradley Blvd. Chevy Chase, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Margaret E. Callan, M.D.</u>							
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/19/60</u>		<u>Parklawn Cemetery</u>		<u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<u>The S. H. Hines Co. 2901 14th St. N.W.</u>				<u>FEB 18 '60</u>		<u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2187

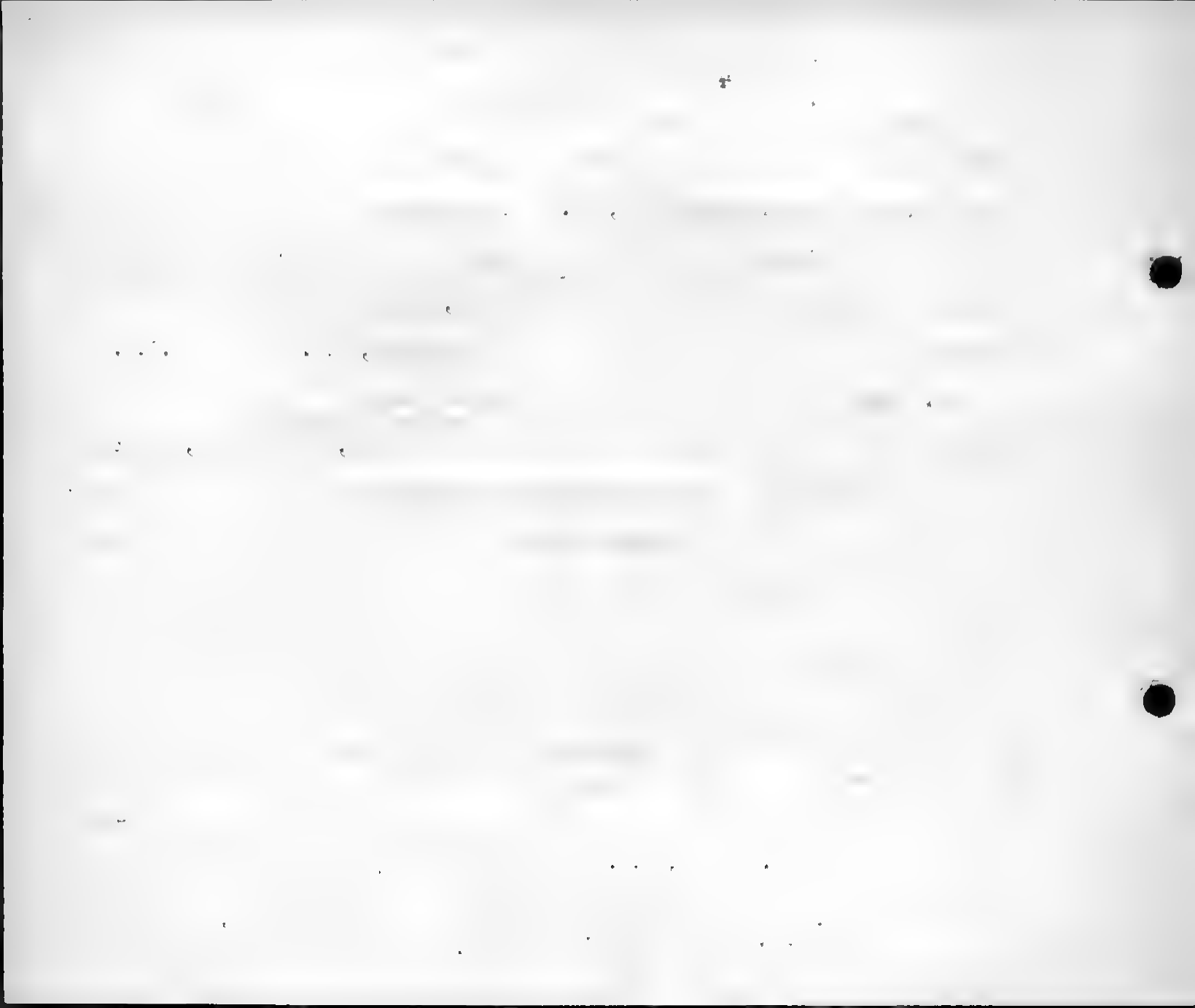
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived) (If institution, Residence before adm'ssion) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 51 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 2 D Gardenway							
3. NAME OF DECEASED (Type or print) First Middle Last Michael Dix Boone				4. DATE OF DEATH Month Day Year February 8 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1948	
9. AGE (In years last birthday) 11 yrn.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Dix C. Boone				14. MOTHER'S MAIDEN NAME Helen Crowley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure & hypotension							
196.9 DUE TO Osteogenic Sarcoma							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 19, 1952 to February 8, 1960 , that I last saw the deceased alive on February 8, 1960 , and that death occurred at 12:10 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-8-60							
ACTUAL SIGNATURE Charles E. Mengel				National Institutes of Health			
PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D.				Bethesda 14, Maryland			
22a. BURIAL CREATION, REMOVAL (Specify)		22b. DATE THEREOF Burial Feb. 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Chambers				24. REC'D BY REGISTRAR FEB 10 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2188

CERTIFICATE OF DEATH

Reg. Dist. No.

02118

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institut. on. Res. dence before admission) a. STATE Maryland				b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 53 hr. 1 min.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS Pendle School Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Boswell				4. DATE OF DEATH Month Day Year February 21 1960							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 18, 1960		9. AGE (In years last birthday) — yrs. — mos. — days — hrs. — min.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Anthony L. Boswell Jr.				14. MOTHER'S MAIDEN NAME Martha Clara Simons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				INFORMANT Martha C. Boswell Address Pendle School Road Fulton, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage (rt. temporal region) 710.5 DUE TO Prematurity (one of twins) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/18, 1960, to 2/21, 1960, that I last saw the deceased alive on 2/21, 1960, and that death occurred at 3:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SIGNATURE Charles S. Whitaker, M.D. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 2/22/60		22c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery		22d. LOCATION (City, town, or county) (State) Clarksville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Address Walter H. Woodward, Funeral, Md.						24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

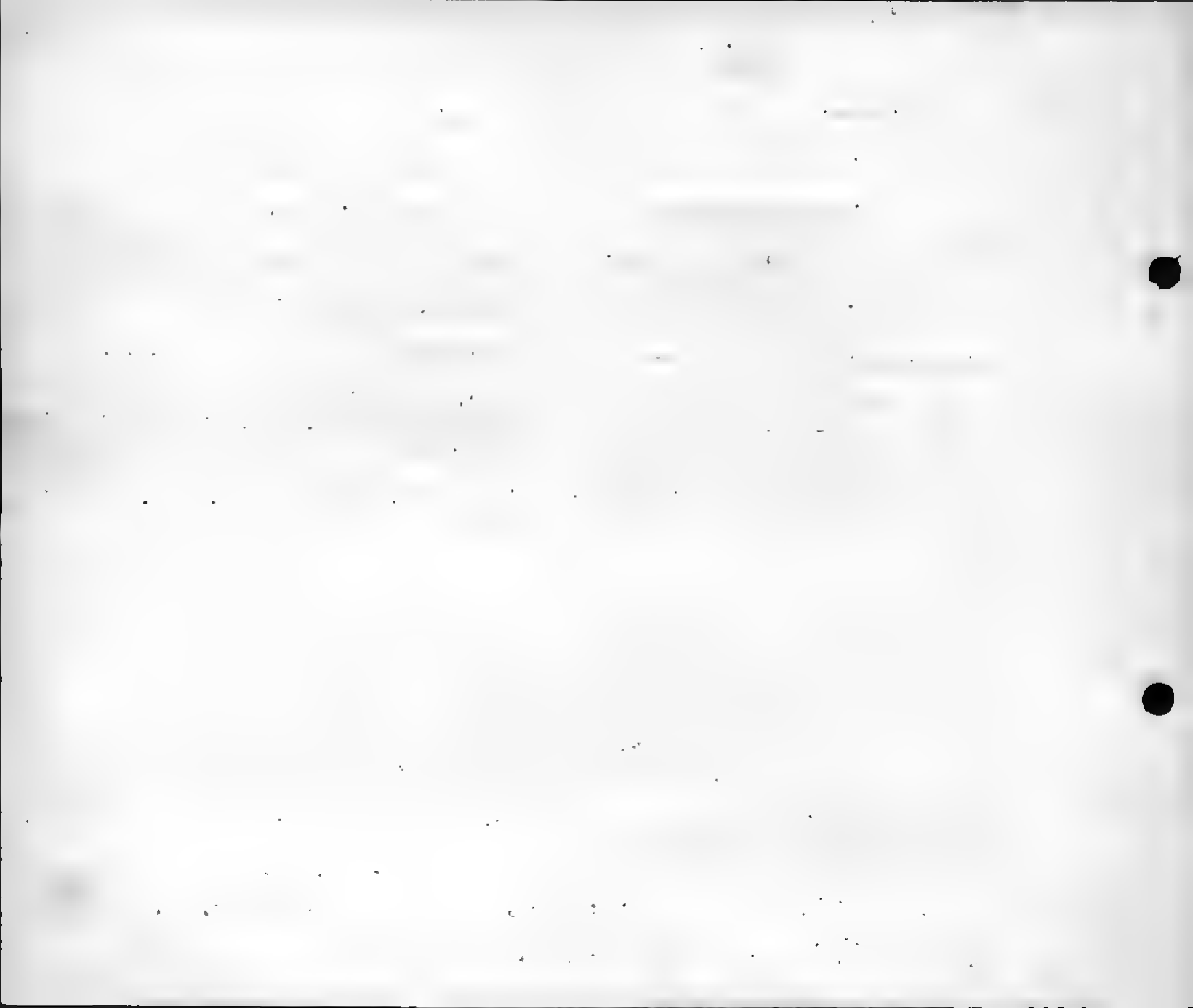
2189

CERTIFICATE OF DEATH

Reg. Dist. No.

02119

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 19 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Moses Middle Eli Last Boyd		4. DATE OF DEATH Month February Day 9 Year 19 60	
5. SEX male	6. COLOR OR RACE N negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1880
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) day laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) day laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Boyd		14. MOTHER'S MAIDEN NAME Rachel Prather	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Rachel Macabee 9404 Kansas Ave; Silver Spring daughter		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Bilateral (Bacterial) Silage 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8 , 19 60 , to Feb 9 , 19 60 , that I last saw the deceased alive on FEB 9 , 19 60 , and that death occurred at 2:45 A.M., from the causes and on the date stated above			
ACTUAL SIGNATURE F. P. Andrews M.D.		ADDRESS (Street, city or town, state) 4201 Essenden St N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) P. P. Andrews		DATE SIGNED 2-9-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/60	
22c. NAME OF CEMETERY OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sudder		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

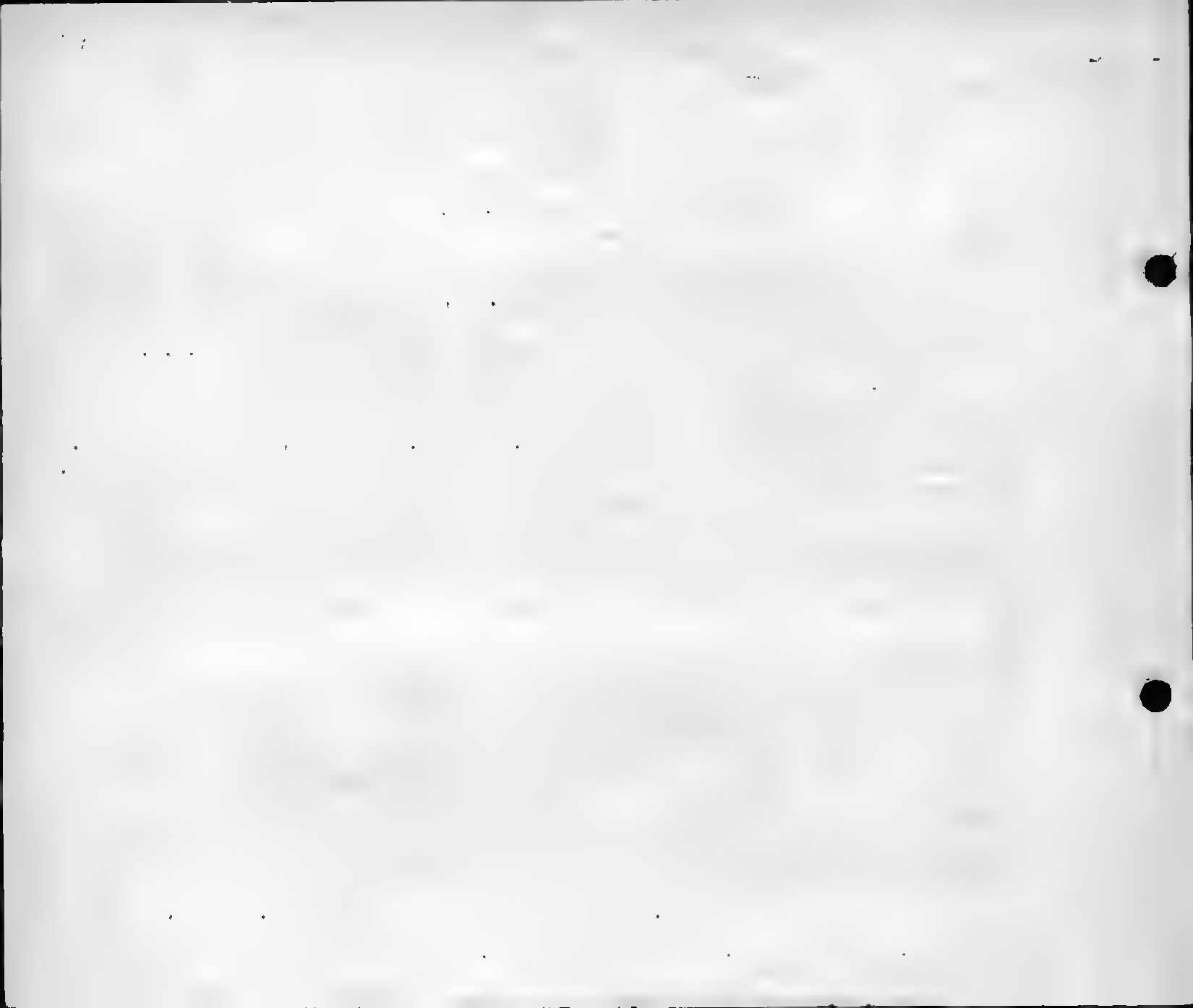
02120

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 2135 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>816 Richmond Cir</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Henry J. Brandlein</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1960</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1889</u>		9. AGE (in years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Brandlein</u>				14. MOTHER'S MAIDEN NAME <u>Francesca Fickert</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>100-07-9423</u>				17. INFORMANT Address <u>Mrs. Pearl E. Brandlein, 816 Richmond Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>2-19-60</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/22/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>								ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hand</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

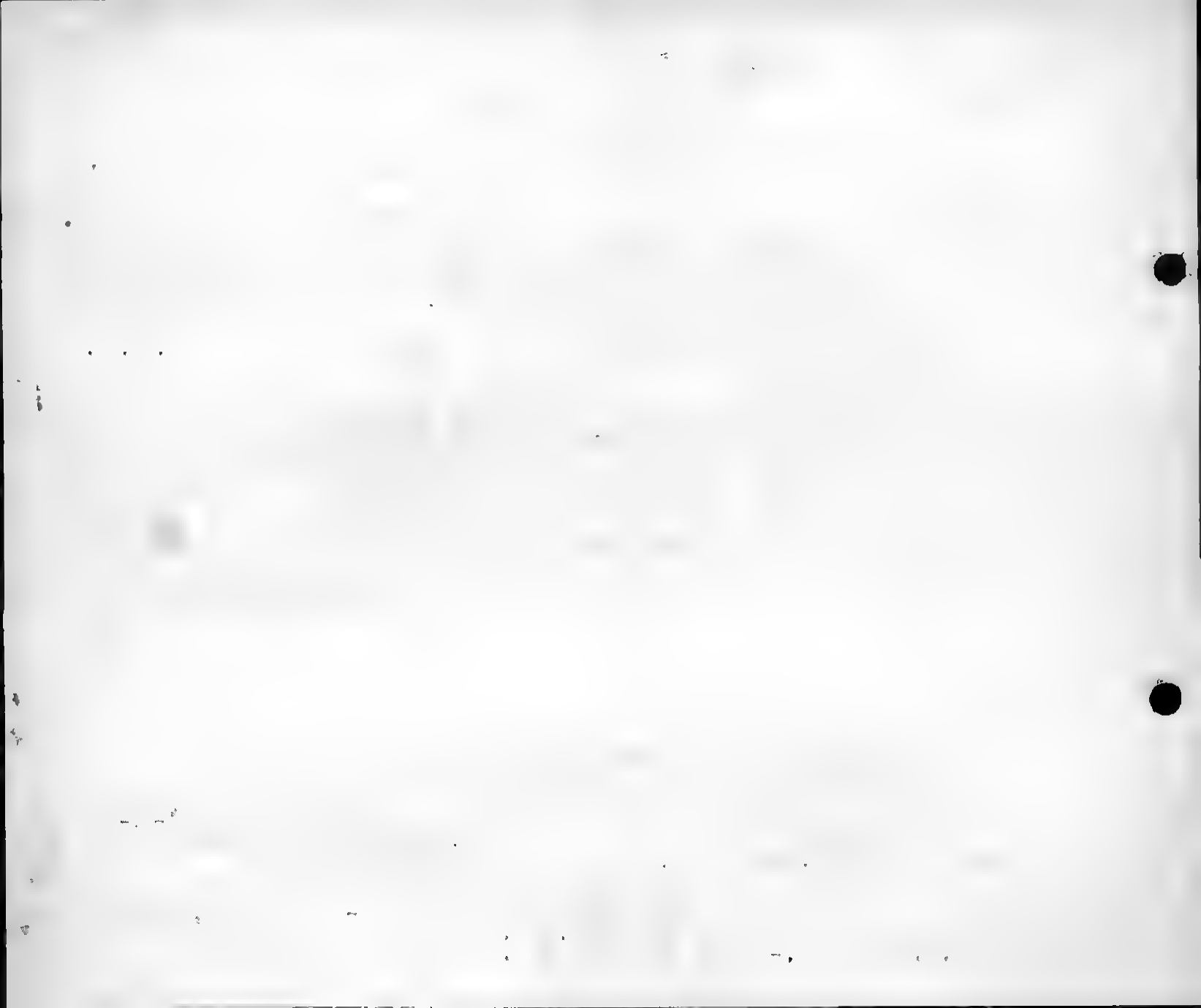
02121

2190

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 84 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16 (Westgate, Md.)			
				d. STREET ADDRESS 5011 Jamestown Road			
3. NAME OF DECEASED (Type or print) First Nancy Middle Groom Last Bream				4. DATE OF DEATH Month February Day 26 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1920		9. AGE (In years last birthday) 39 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Laboratory		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Claudius Murchison				14. MOTHER'S MAIDEN NAME Constance Waterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO 17X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Carcinomatous DUE TO Carcinoma of Breast (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 4, 1959 to February 26, 1960 , that I last saw the deceased alive on February 26, 1960 , and that death occurred at 1:05 p.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center 2-26-60 DATE SIGNED ACTUAL SIGNATURE Louis V. Aviola M.D. PHYSICIAN'S NAME (Type) LOUIS V. AVIOLI, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. - Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.				24a. REC'D BY REGISTRAR DATE FEB 29 1960		24b. REGISTRAR'S SIGNATURE Arthur J. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2167

CERTIFICATE OF DEATH

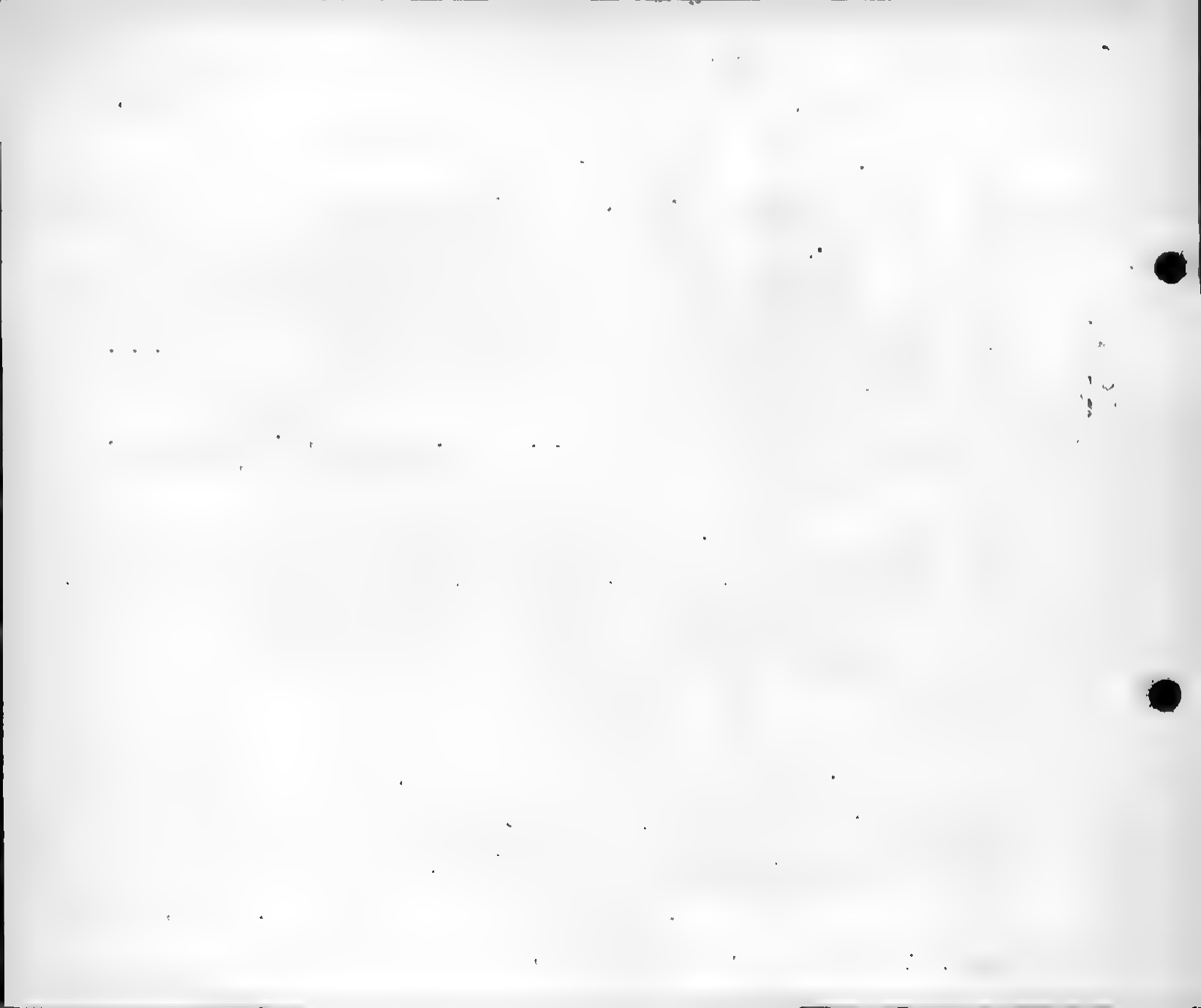
Reg. Dist. No.

02122

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS REST HOME		e. STREET ADDRESS 1613 Oaklawn Court	
3. NAME OF DECEASED (Type or print) First H. Middle ALBERT Last BUHLER		4. DATE OF DEATH Month Feb Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/73
9. AGE (In years lost birthday) 86 yrs		10. IF UNDER 1 YEAR: Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer (retired)		10b. KIND OF BUSINESS OR INDUSTRY Owner of Grocery Store	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRIEDRICH BUEHLER		14. MOTHER'S MAIDEN NAME KAROLINE GOLDNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Alma B. Schaeffer, 1613 Oaklawn Ct. Silver Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 321X DUE TO Cerebral Hemorrhage			
(b) Senile Arteriosclerosis			
(c) 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 19 46 to 15 Feb 19 60 , that I last saw the deceased alive on 12 Feb 19 60 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M B Queen		ADDRESS (Street, city or town, state) 7112 Willow Run	
PHYSICIAN'S NAME (Type) M B QUEEN		DATE SIGNED 15 Feb 1960	
22a. BURIAL CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 2/18/60	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR FEB 17 '60	
ADDRESS SILVER SPRING, MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

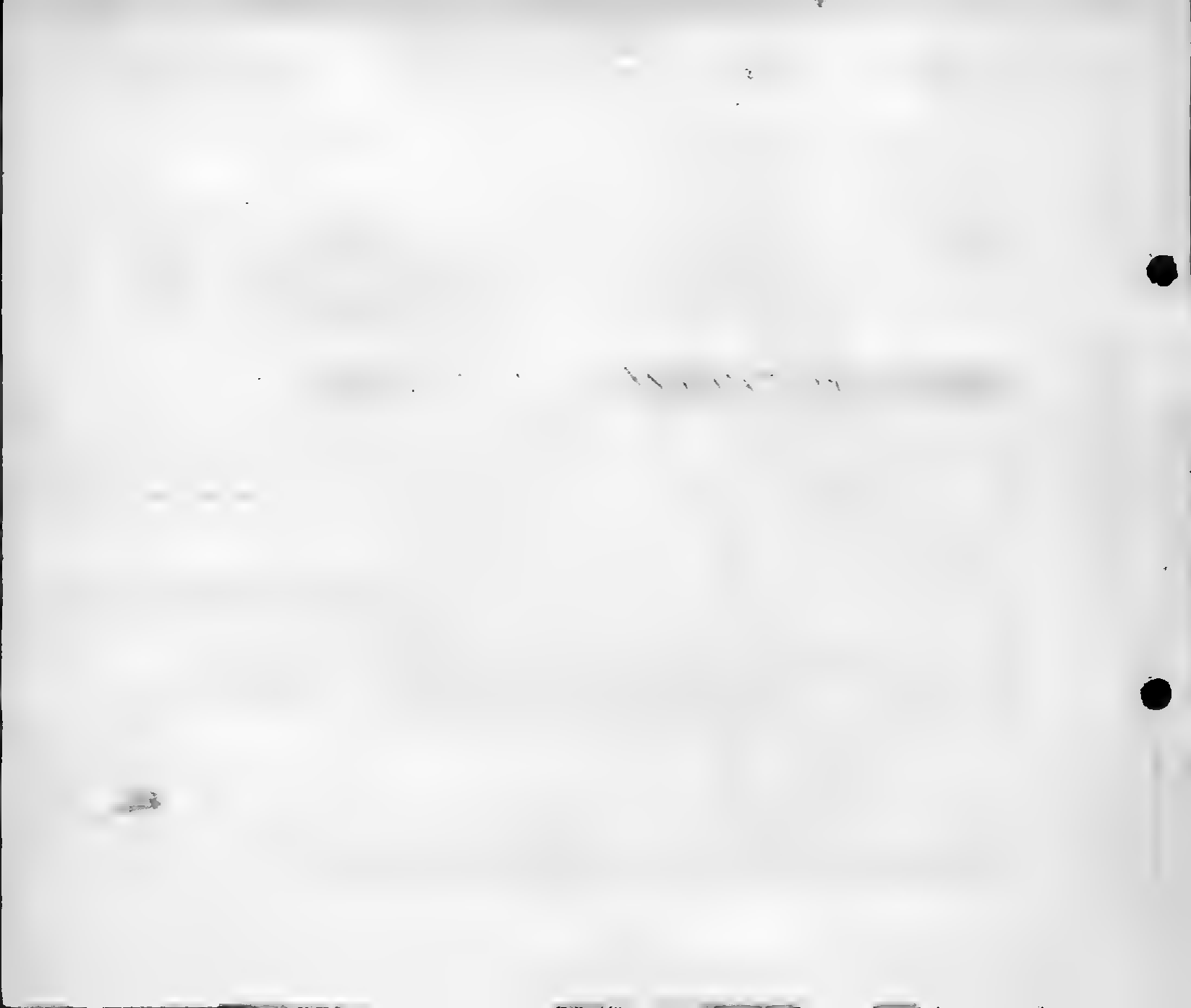
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTONTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>6206 KATHIE LANE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Lerch Callan</u>		4. DATE OF DEATH Month Day Year <u>Feb 6 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/81</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John J. B. Lerch</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE LEPPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Eleanor C. Craun, Bethesda, Md</u>		Address <u>Bethesda, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> DUE TO <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Con. Heart Failure Comp.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 8, 1960</u> , to <u>FEB 13, 1960</u> , that I last saw the deceased alive on <u>2/13, 1960</u> , and that death occurred at <u>4:58</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Brennan</u>		ADDRESS (Street, city or town, state) <u>Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>		DATE SIGNED <u>2/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>At 10, 1960</u>	22b. DATE THEREOF <u>At 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. A. Saffell</u>		ADDRESS <u>475 H. N. Wynd</u>	
24. REG'D. BY REGISTRAR <u>FEB 10 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	

NA F-0537

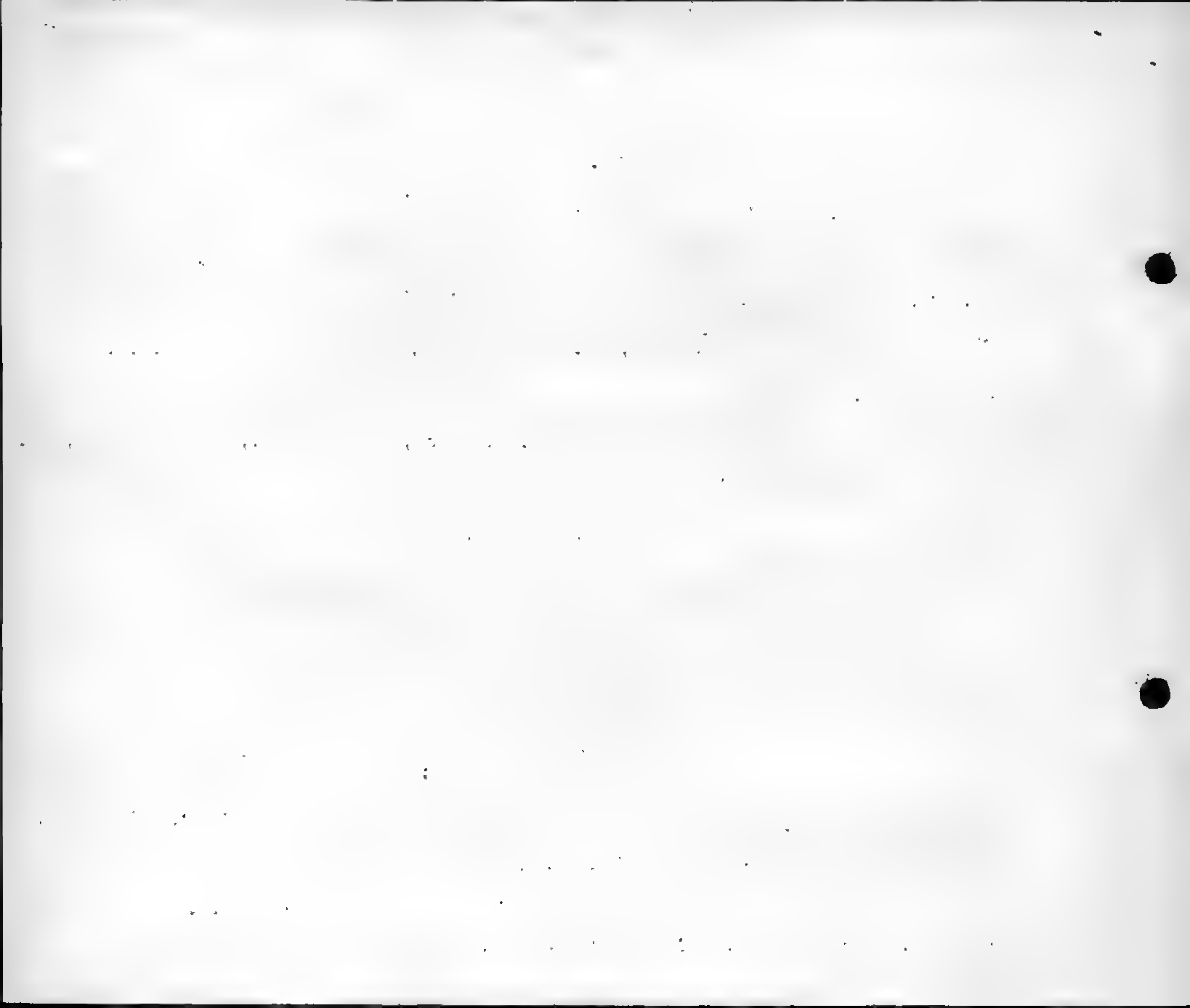
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS A15 (4)
ISM 9/58

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b one week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanit.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie ELIZABETH Chase		4. DATE OF DEATH Month February Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep 9, 1872
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY Assessor's office Rockville, Md.	
11. BIRTHPLACE (State or foreign country) Trenton, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JEFFERSON C. POWERS		14. MOTHER'S MAIDEN NAME MARY ELY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Ben Shaw, 21 Shaw Ave., Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Infection DUE TO (b) Chronic debilitation DUE TO (c) Chronic heart failure, compensated CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.4			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26 , 19 60 , to Feb 1 , 19 60 , that I last saw the deceased alive on Feb 1 , 19 60 , and that death occurred at 11:35 AM from the causes and on the date stated above ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED Feb 1, 1960			
ACTUAL SIGNATURE Robert T. Thibadeau		PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/4/60	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. BUNNARY, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



2192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 7 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE OAK d. STREET ADDRESS RT. #2 STEWART LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUTH ROSETTA CHRISTIAN				4. DATE OF DEATH Month Day Year FEBRUARY 12 19 60			
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/04	
9. AGE (In years last birthday) 55		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CHARLES HENRY JACKSON				14. MOTHER'S MAIDEN NAME CINDERELLA JACKSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. HOSPITAL RECORDS OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX WITH METASTASES DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 YEAR							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 5 , 19 60 , to FEB. 12 , 19 60 , that I last saw the deceased alive on FEB. 12 , 19 60 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town state) DATE SIGNED 3/13/60							
ACTUAL SIGNATURE <i>[Signature]</i> PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.				M.D. SANDY SPRING, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/15/60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR FEB 18 '60		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2137

CERTIFICATE OF DEATH

Reg. Dist. No.

02126

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

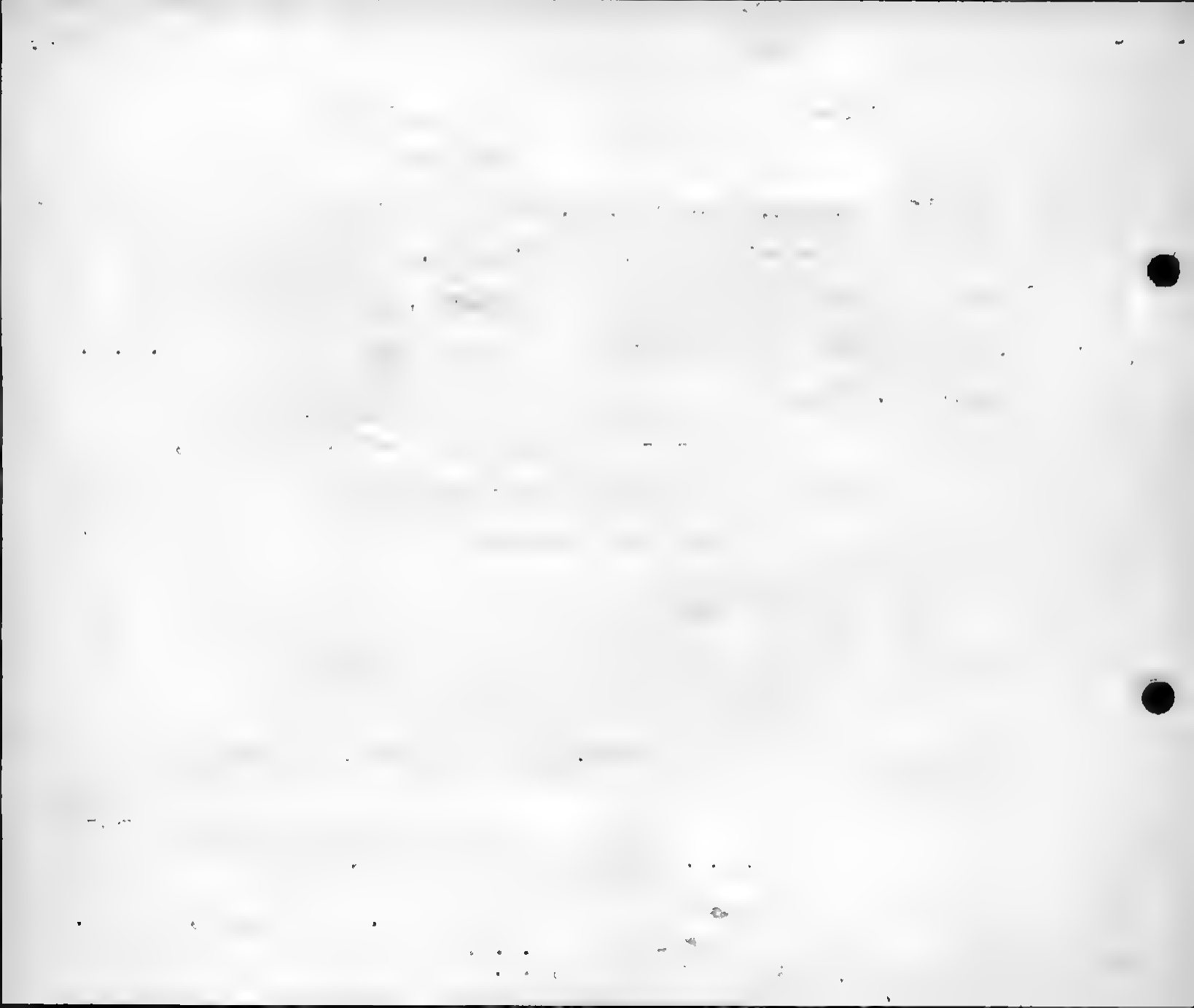
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Harvey</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-96</u>
9. AGE (n years lost, birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Clark</u>		14. MOTHER'S MAIDEN NAME <u>Laura Goddard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>Wife - Mrs. Margaret Clark - same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> DUE TO (b) <u>two recently perforated gastric ulcers</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>congestive cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>18 hours</u>	
PART II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary sclerosis with occlusion; myocardial insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>58</u> , to <u>FEB 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 16</u> , 19 <u>60</u> , and that death occurred at <u>6:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert K. Krichmar</u> M.D.		ADDRESS (Street, city or town, state) <u>7733 ALASKA AVE NW WASH DC</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT K. KRICHMAR</u>		DATE SIGNED <u>FEB 17 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Westbury Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. ...</u>		ADDRESS <u>1400 ...</u>	
24a. REC'D BY REGISTRAR <u>FEB 18 1960</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	



02127

MEDICAL CERTIFICATION

V5 A15 (4)
15M 9/58



2194 CERTIFICATE OF DEATH

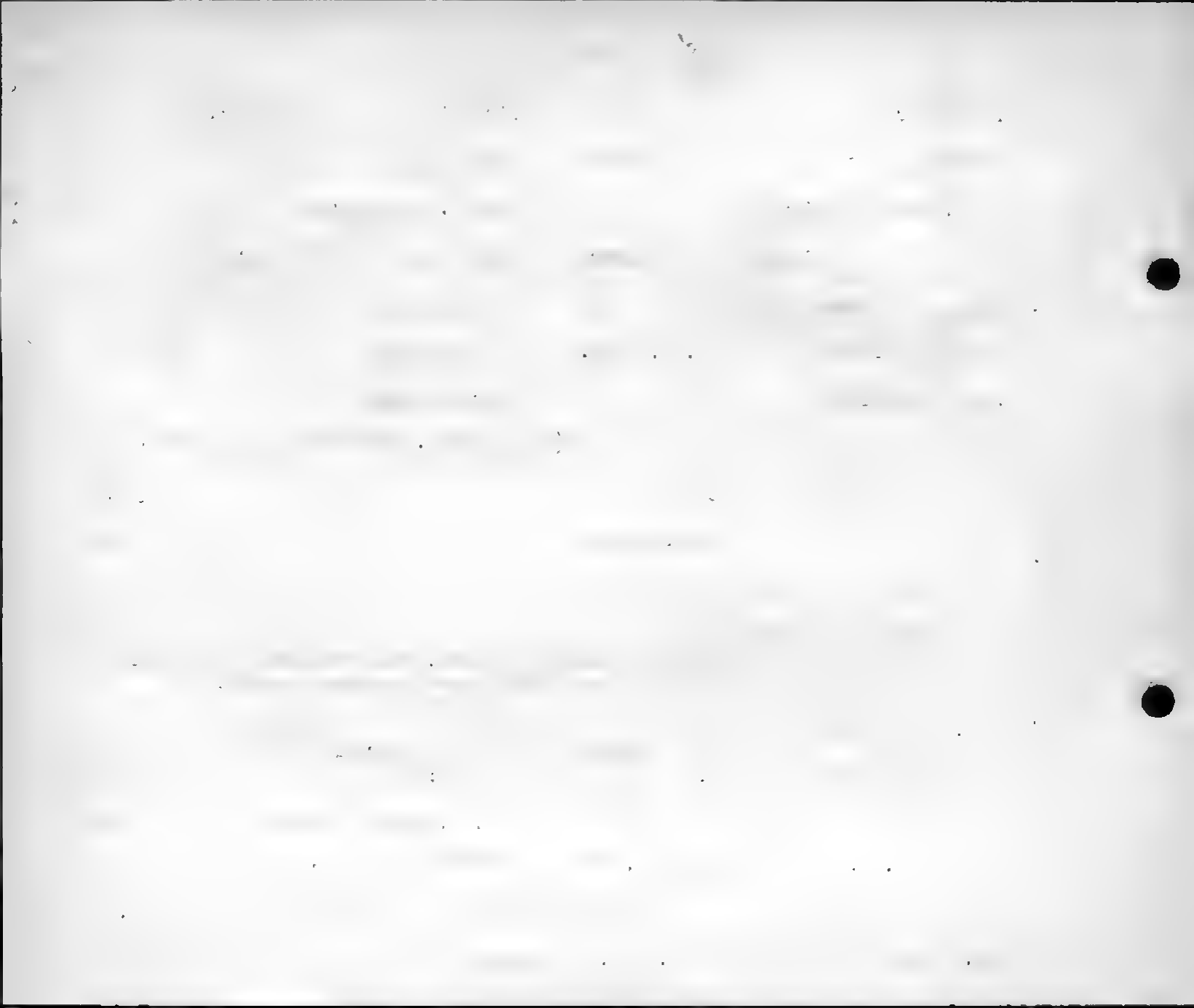
Reg. Dist. No.

02128
215

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Arlington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital			d. STREET ADDRESS 4439 N. 17th Street		
3. NAME OF DECEASED (Type or print) First Middle Last William Edward CORFITZEN			4. DATE OF DEATH Month Day Year February 4 19 60		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-08		9. AGE (In years last birthday) 52 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Edward CORFITZEN			14. MOTHER'S MAIDEN NAME Theresa KEEGAN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		INFORMANT Address (W) Regina D. Corfitzen, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 357X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Syngomyelia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 days 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Left Hip					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell while walking at home. Fall was due to instability caused by his central nervous system disease.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3:25 p. m. 11/20/ 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) Arlington		(County) (State) Virginia	
21. I certify that I attended the deceased from December 22, 19 59 , to February 4, 1960 , that I last saw the deceased alive on February 3, 19 60 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above					
ACTUAL SIGNATURE Frank J. Dawson II		M.D. U. S. Naval Hospital		DATE SIGNED 2-4-60	
PHYSICIAN'S NAME (Type) F. J. DAWSON II, LT, MC, USN Bethesda 14, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-60		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens	
				22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Hos. Gawler's & Sons			24a. REC'D BY REGISTRAR FEB 8 '60		24b. REGISTRAR'S SIGNATURE Wm. S. Thayer
ADDRESS Hos. Gawler's & Sons, 1756 Pa. Ave., NW, WashDC					

Montgomery CO., Deputy Medical Examiner notified.

MEDICAL CERTIFICATION



2195

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 33 days			2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE District of Columbia b. COUNTY			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			d. STREET ADDRESS 3023 14th St., N.W. - Apt. 713			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES SHEERS CRAMER			4. DATE OF DEATH Month Day Year February 11 1960			5. SEX Female			6. COLOR OR RACE Caucasian			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1-16-93			9. AGE (In years last birthday) yrs 67			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer			10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.			11. BIRTHPLACE (State or foreign country) Connecticut			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel SHEERS			14. MOTHER'S MAIDEN NAME Rosaland BURKO								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			INFORMANT (H) J. A. Cramer, same as #2 above			Address			17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, nephrosclerosis 260X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). Peripheral Vascular disease to gangrene AS HD			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 9, 1960 , to February 11, 1960 , that I last saw the deceased alive on February 11, 1960 , and that death occurred at 2:20P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. G. Galbraith, Jr. U. S. Naval Hospital 2-11-60 ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) R. G. GALBRAITH, JR., LT, MC, USN Bethesda 14, Maryland																							
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation			22b. DATE THEREOF 2-13-60			22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory			22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.			23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines			24a. REC'D BY REGISTRAR FEB 15 '60			24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

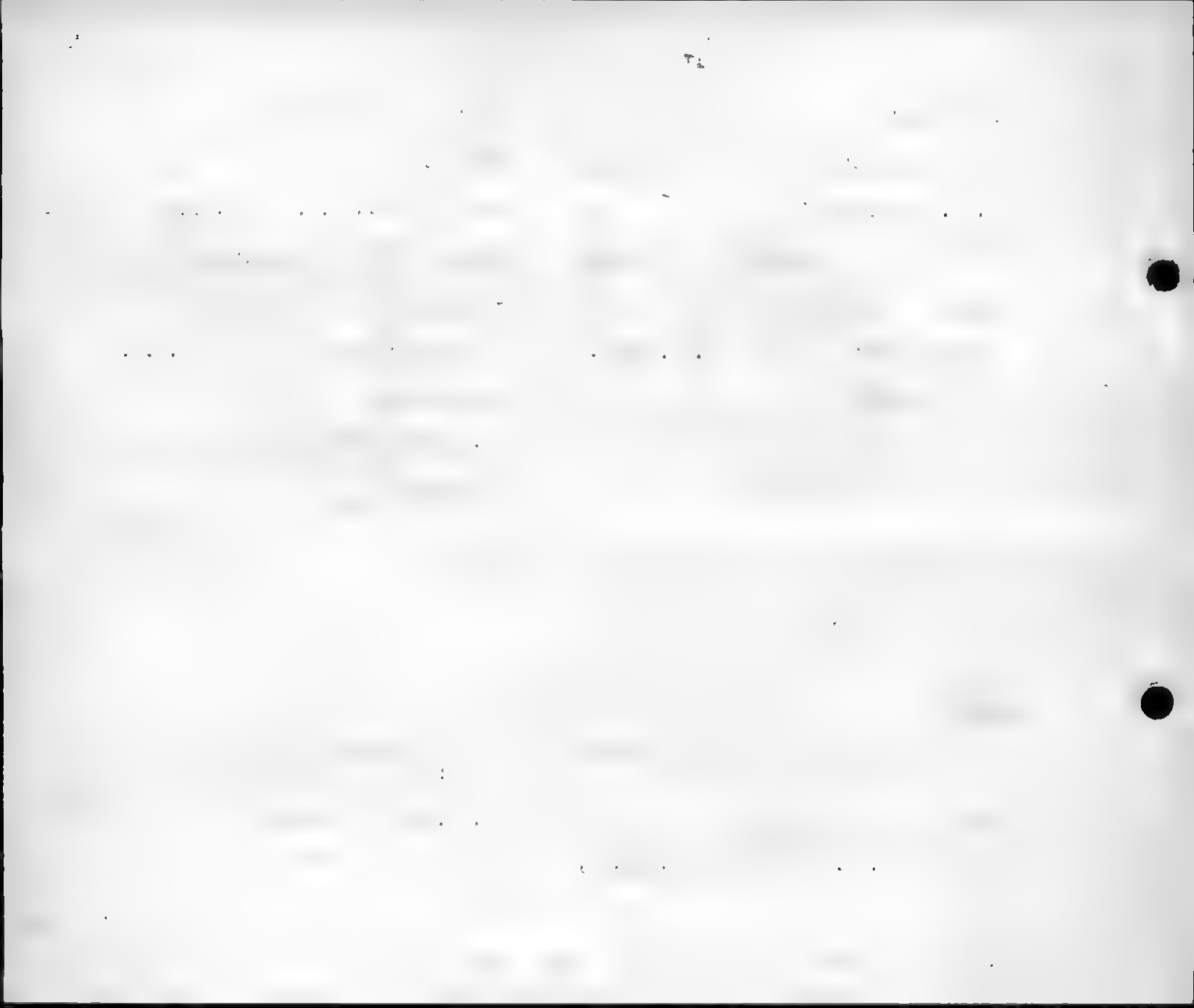
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2195 CERTIFICATE OF DEATH

Reg. Dist. No.

02130

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLARKSBURG RT 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JDA JANE CRANFORD</u>				4. DATE OF DEATH Month Day Year <u>2 8 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31 1879</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>THOMAS E MOXLEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA RILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>HORACE WILLIAMS FREDERICK MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>155.1 METASTATIC CANCER OF LIVER</u> DUE TO (b) <u>PRIMARY CANCER OF GALL BLADDER</u> DUE TO (c) <u>ORIBILE DUCTS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 5, 1957</u> , to <u>Feb 8, 1960</u> , that I last saw the deceased alive on <u>Feb 7, 1960</u> , and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. F. MEADORS, MD</u> M.D.						ADDRESS (Street, city or town, state) <u>MAIN STREET DAMASCUS, MD</u>	
DATE SIGNED <u>2/8/60</u>							
PHYSICIAN'S NAME (Type) <u>G. F. MEADORS, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence C. Early</u>				ADDRESS <u>FREDERICK MD</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

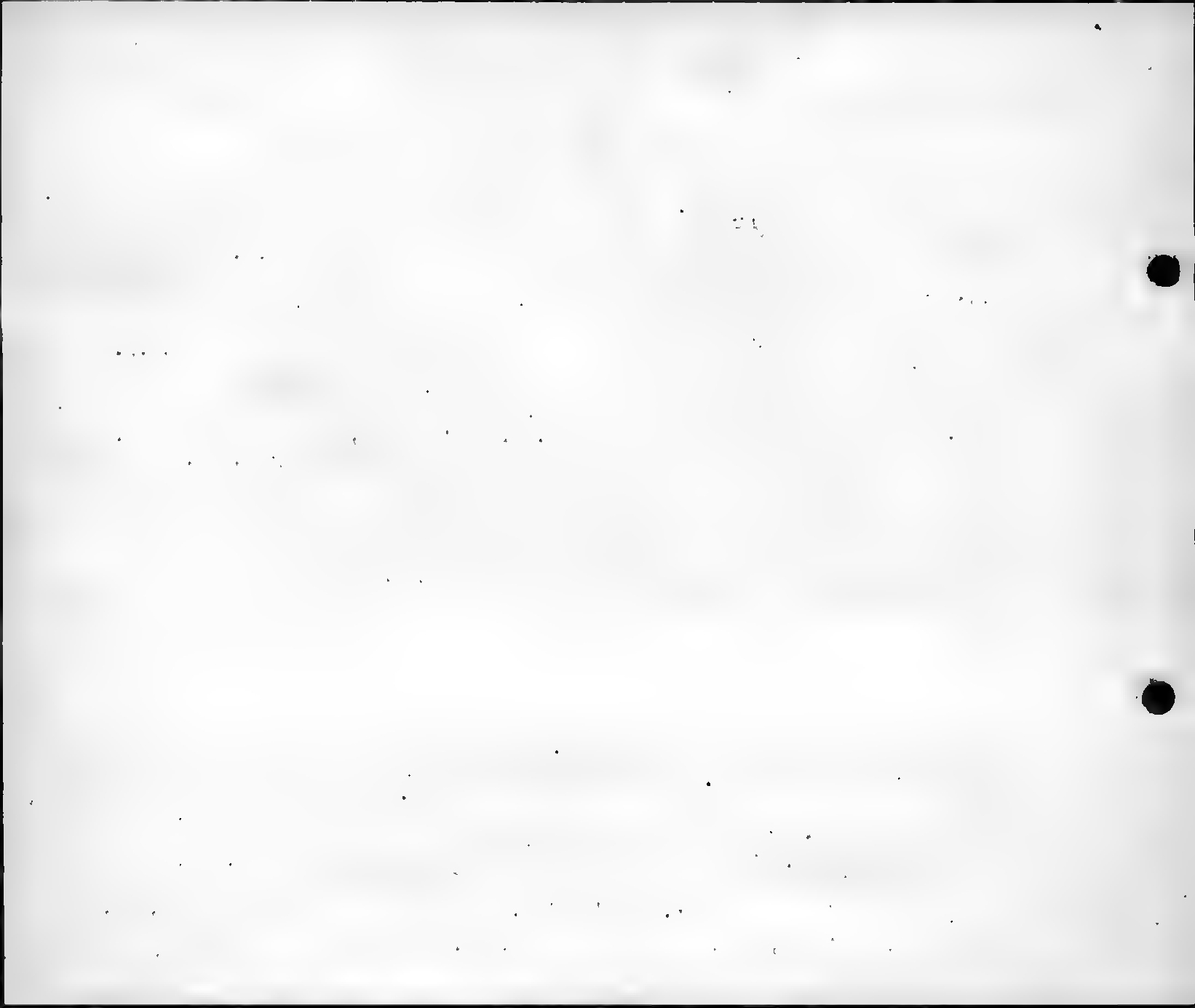
2197

CERTIFICATE OF DEATH

Reg. Dist. No. 02131

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST GLEN		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST GLEN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9805 ROSENSTEEL AVE.		d. STREET ADDRESS 9805 ROSENSTEEL AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ETHEL Middle MARIE Last CULVER		4. DATE OF DEATH Month FEB. Day 5 Year 19 60	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/9/98
9 AGE (In years last birthday) yrs 61		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE HENRY CULVER		14. MOTHER'S MAIDEN NAME CAROLINE DOROTHY CULVER GRAF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Mr. F. Earl Culver, 3006 Homewood Pkwy. Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 171X DUE TO Uterine due to Carcinoma of Cervix Uteris with local metastases. Conditions, if any which gave rise to immediate cause (a): stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1959 to February 5, 1960 that I last saw the deceased alive on Feb 5 1960, and that death occurred at 3:34 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John J. Curry M.D. 10670 Georgia Ave 2/6/60 Salvatore Spicuglia			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/8/60	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATH. CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond W. Ziska		24a REC'D BY REGISTRAR DATE FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

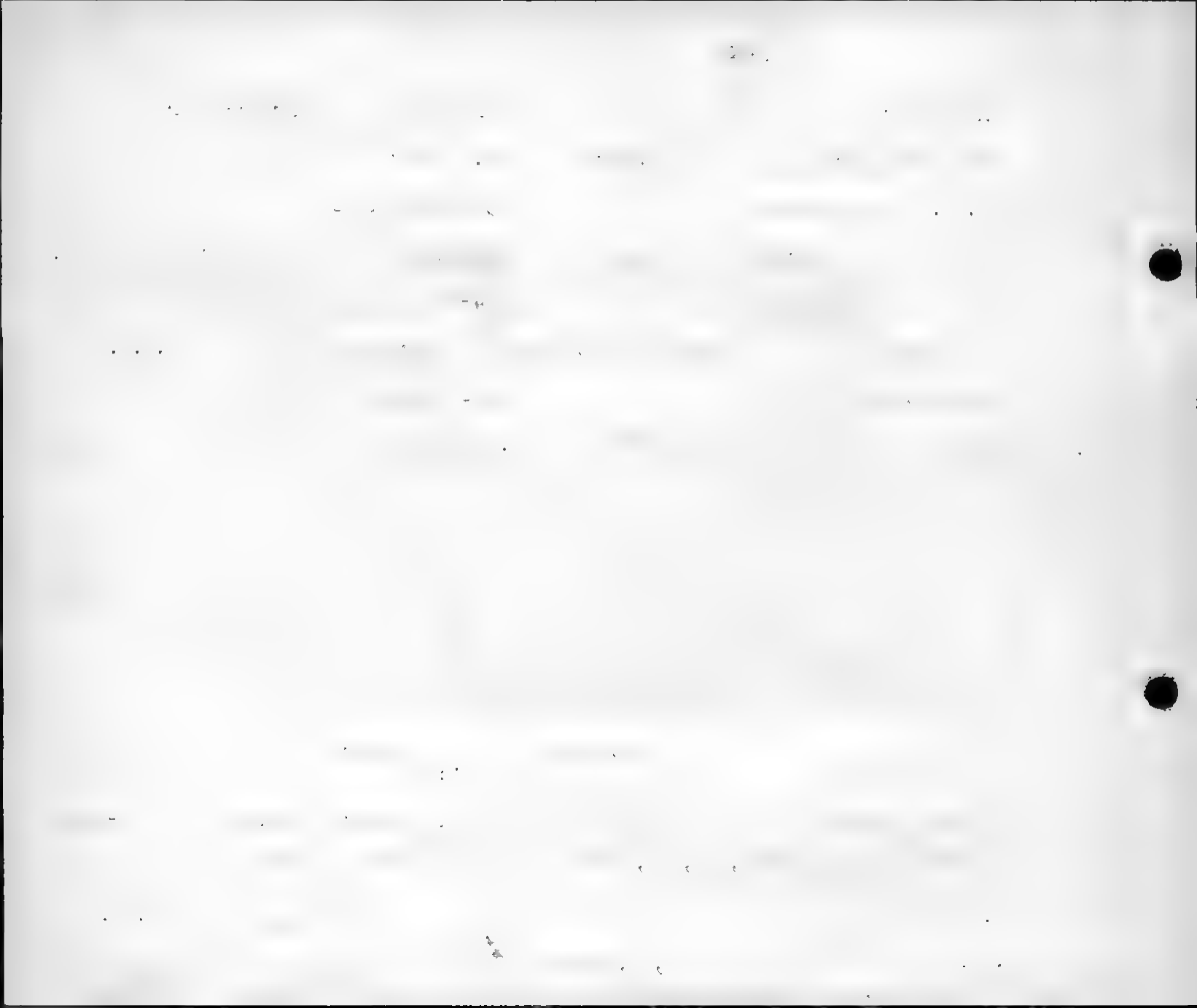
2198

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02132

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o STATE Maryland o COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 156 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Ranier 1647			
f. STREET ADDRESS 4504 31st Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Orion Middle Lee Last CURTIS				4. DATE OF DEATH Month February Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-95	
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 0 Min.		11. IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman				10b. KIND OF BUSINESS OR INDUSTRY Washington, DC Police			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James CURTIS				14. MOTHER'S MAIDEN NAME Alice Kempel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO 579-40-4807			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO (b) Post necrotic Cirrhosis DUE TO (c) Hepatitis							INTERVAL BETWEEN ONSET AND DEATH 5 days 3 years Jan 1955
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 9, 1959 to February 12, 1960 , that I last saw the deceased alive on February 11, 1960 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John Wood Davis M.D.				ADDRESS (Street, city or town, state) U. S. Naval Hospital			
DATE SIGNED 2-12-60							
PHYSICIAN'S NAME (Type) John Wood DAVIS, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-15-60			
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Washington D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Co., 2901 14th St., NW, Washington, DC				24a. REC'D BY REGISTRAR Feb 15 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02133

2199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>10 years</u>				d. STREET ADDRESS <u>8709 Grant St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8709 Grant St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Danhahl</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>7</u> - Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. SA</u>		13. FATHER'S NAME <u>John Frebert</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Seibert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John G. Danhahl</u> Address <u>8709 Grant St Bethesda Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADAMS-STOKES SYNDROME</u> <u>453.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Conjunctive Heart Failure (440)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>July</u> _____, 19 <u>57</u> , to <u>July</u> _____, 19 <u>60</u> , that I last saw the deceased alive on <u>21</u> <u>7</u> _____, 19 <u>60</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Brennan</u> M.D.				ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geiers Sons Co</u> ADDRESS <u>3605-14 St NW Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

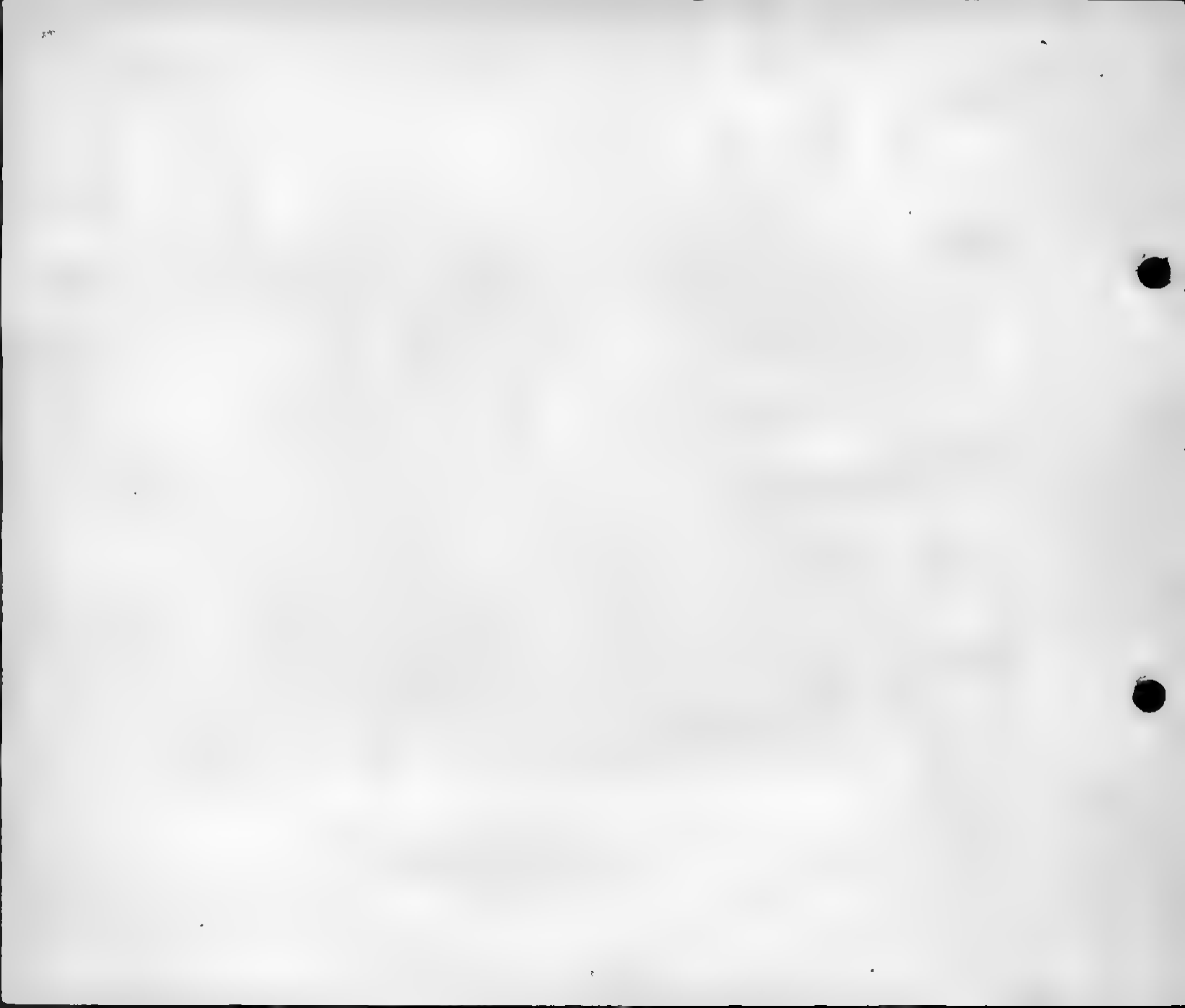
02134

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>9 yr</u>		d. STREET ADDRESS <u>1521 W. Montgomery Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>521 W. Montgomery Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank J. Davis</u>		4. DATE OF DEATH <u>Feb 7 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 4 1885</u>	
9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County official</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Davis</u>		14. MOTHER'S MAIDEN NAME <u>Emma Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>217-38-7502</u>	
17. INFORMANT <u>Susie Davis (wife)</u>		Address <u>Stevie</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4:20.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> (a), stating the underlying cause last. (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>Feb 7, 1960</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	



2200

CERTIFICATE OF DEATH

Reg. Dist. No.

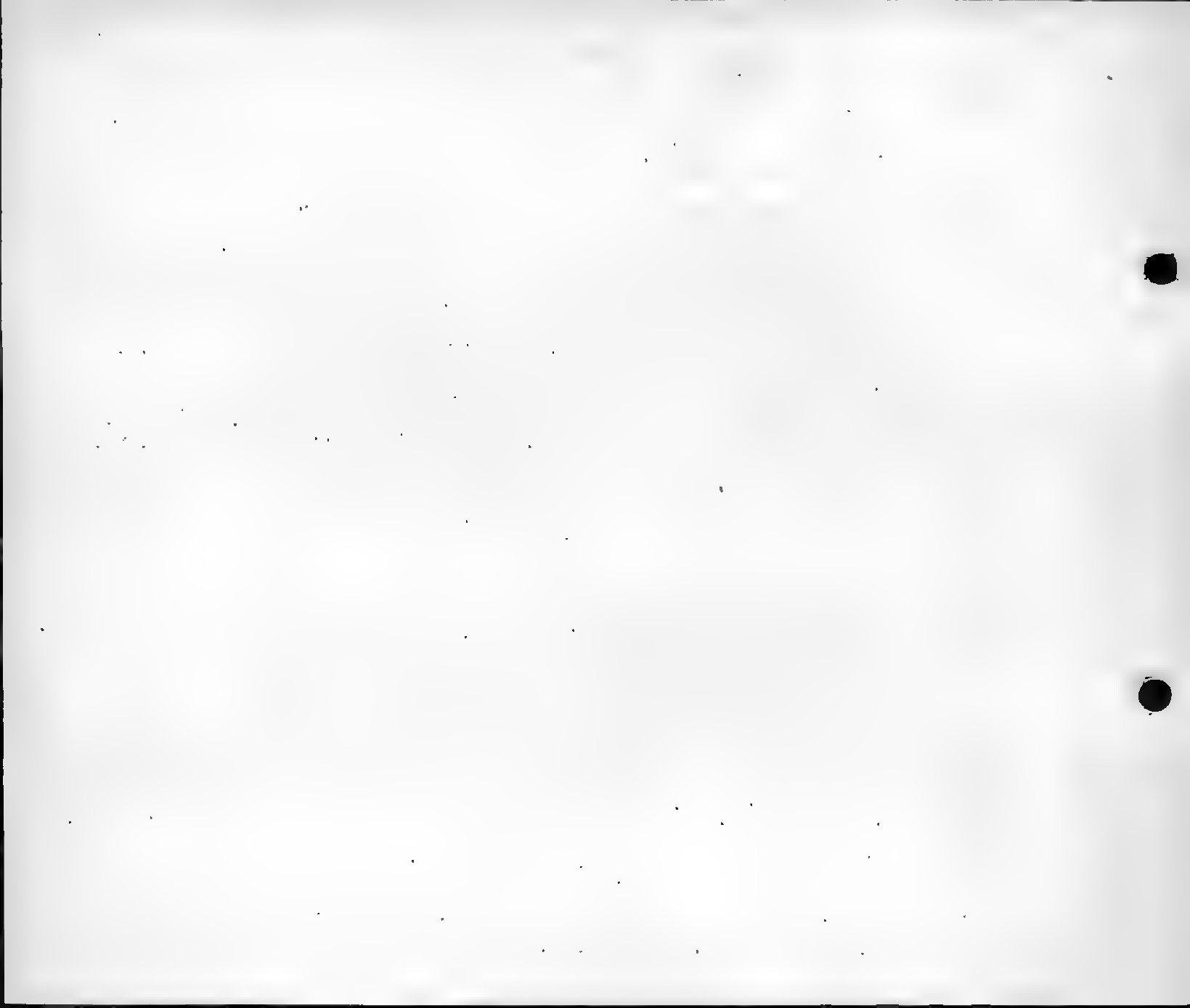
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>6904 Maple Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Hood</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7/74</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jefferson Davis</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Hood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Demaris Davis Hearn</u>		18. ADDRESS <u>6904 Maple Ave. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Septicemia</u> <u>692.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Severe cellulitis rt. face</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-8 hrs</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Arteriosclerosis General (2) Bronchiectasis, severe</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 17, 1957</u> , to <u>Feb 17, 1960</u> , that I last saw the deceased alive on <u>Feb 17, 1960</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash 20176</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Hearn</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/58



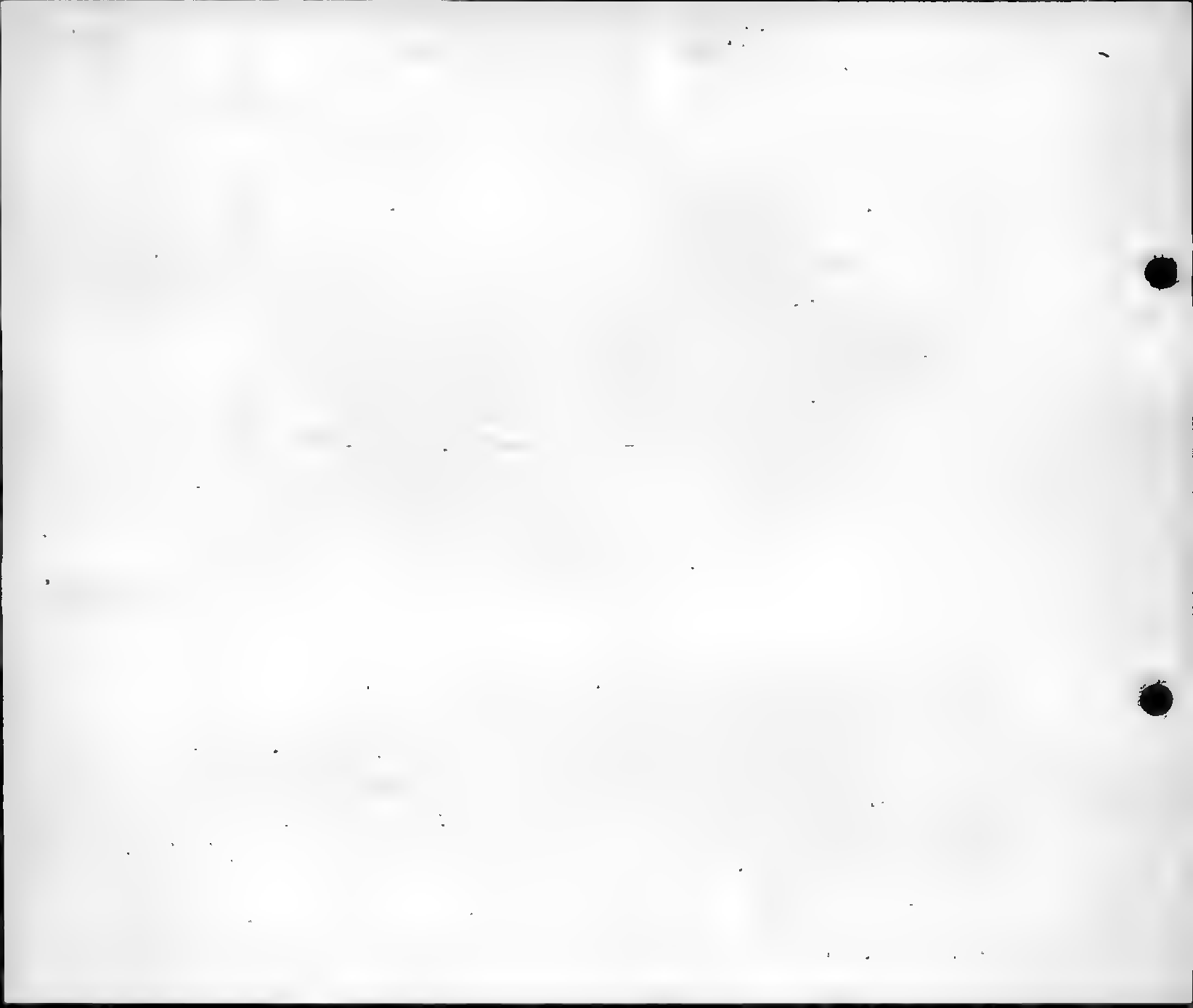
2178

CERTIFICATE OF DEATH

Reg. Dist. No.

02136

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN lb 32 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 S. Adams Street				d. STREET ADDRESS 106 S. Adams Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Walter Thomas Davis				4. DATE OF DEATH Month Day Year February 10 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1881		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days 9 12	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George W. Davis				14. MOTHER'S MAIDEN NAME Elizabeth Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 217-32-1885		INFORMANT Address Mary S. Davis-Wife-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage, right DUE TO hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) arteriosclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 10 days 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 19 30 , 19 February 10, 1960 , that I last saw the deceased alive on February 9, 1960 , and that death occurred at 1540 from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wm. A. Linthicum M.D. 110 S. Washington St. 2/10/60 Rockville, Montg Co., Md.							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) William A. Linthicum					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/60		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 11 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



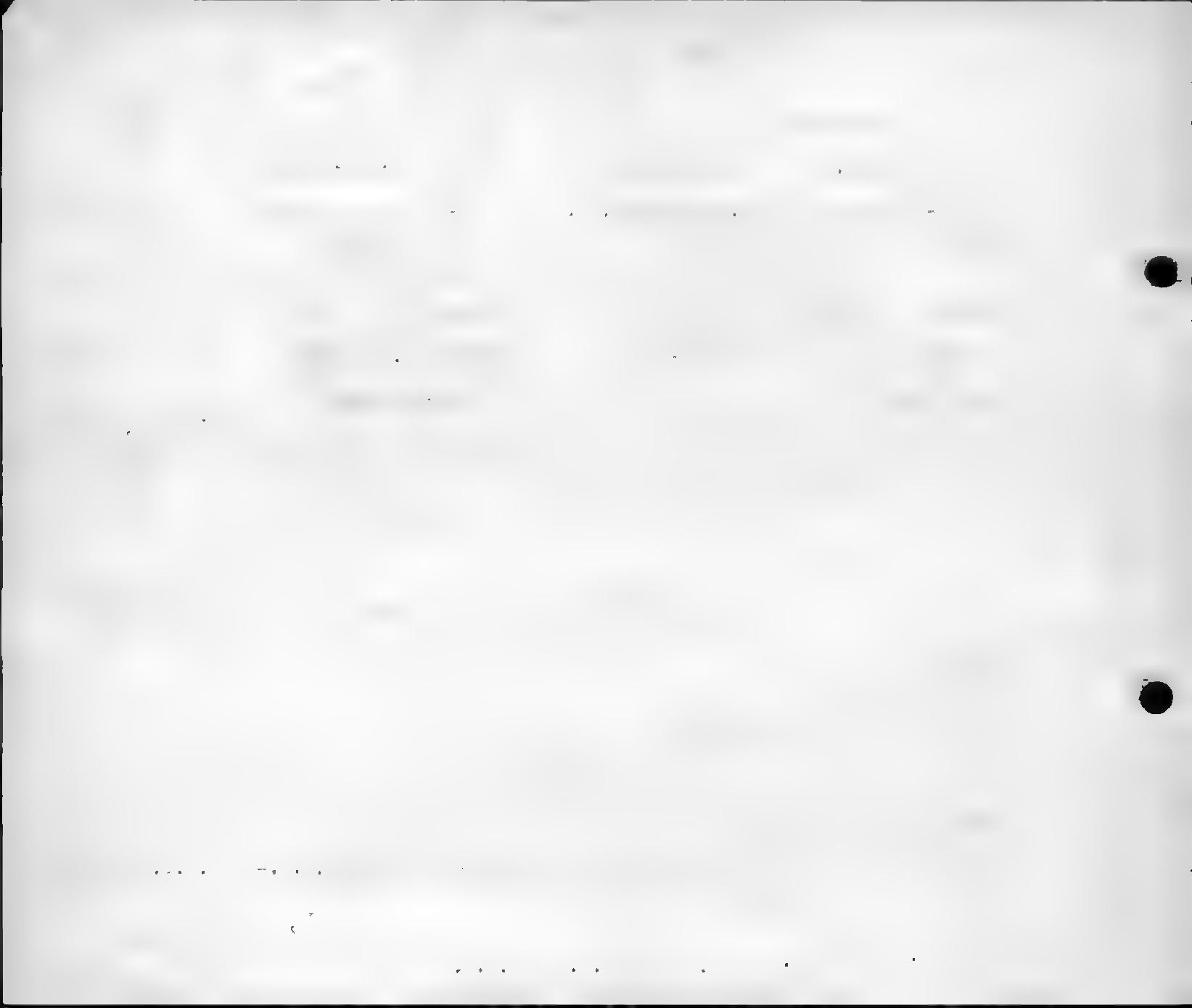
2169 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD.		c. LENGTH OF STAY IN 1b 1 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10018-FREDERICK AVENUE, KENSINGTON, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) May Hastings Dickinson		4. DATE OF DEATH February 14 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1865
9. AGE (In years last birthday) 94 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months 3 Days 26 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER	
11. BIRTHPLACE (State or foreign country) MONTCLAIR, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME TYRUS CASS		14. MOTHER'S MAIDEN NAME MARY MILLARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT KENSINGTON, MARYLAND CATHERINE DICKINSON (NIECE) 10018-FREDERICK AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Hemorrhage 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Acute
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 19, 1959 , to Feb. 14, 1960 , that I last saw the deceased alive on Feb. 13, 1960 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. B. Little		ADDRESS (Street, city or town, state) DATE SIGNED 6911 5th St. N.W. Wash. DC. 2/14/60	
PHYSICIAN'S NAME (Type) A. B. LITTLE, MD		6911- 5th STREET, N.W. - WASH. D.C. 2/14/60	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/17/1960	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) TROY, NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG CO. 1300 N. STREET, N.W. - WASH. D.C.		24a. REC'D BY REGISTRAR FEB 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A15 (4)
15M 9/5B



CERTIFICATE OF DEATH

Reg. Dist. No

2201

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Fred Henry Dunn				4. DATE OF DEATH Month Day Year February 7 1960			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 6, 1902	9 AGE (In years last birthday) 57 yrs	F UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Dunn				14. MOTHER'S MAIDEN NAME Florence McGaha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Stomach Ulcer DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1-2 days ? weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Infarcts, Aortic Stenosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greenville		(County)		(State)
21. I certify that I attended the deceased from January 17, 1960 to February 7, 1960 that I last saw the deceased alive on February 7, 1960 and that death occurred at 10:35 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 2-7-60							
ACTUAL SIGNATURE Charles A. Chidsey		M.D. The Clinical Center					
PHYSICIAN'S NAME (Type) CHARLES A. CHIDSEY, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/10/60		22c. NAME OF CEMETERY OR CREMATORY Greenville		22d. LOCATION (City, town, or county) (State) Greenville SC	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. Chidsey				ADDRESS 5100 W. Main St.		24a. REC'D BY REGISTRAR DATE FEB 10 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Rine			

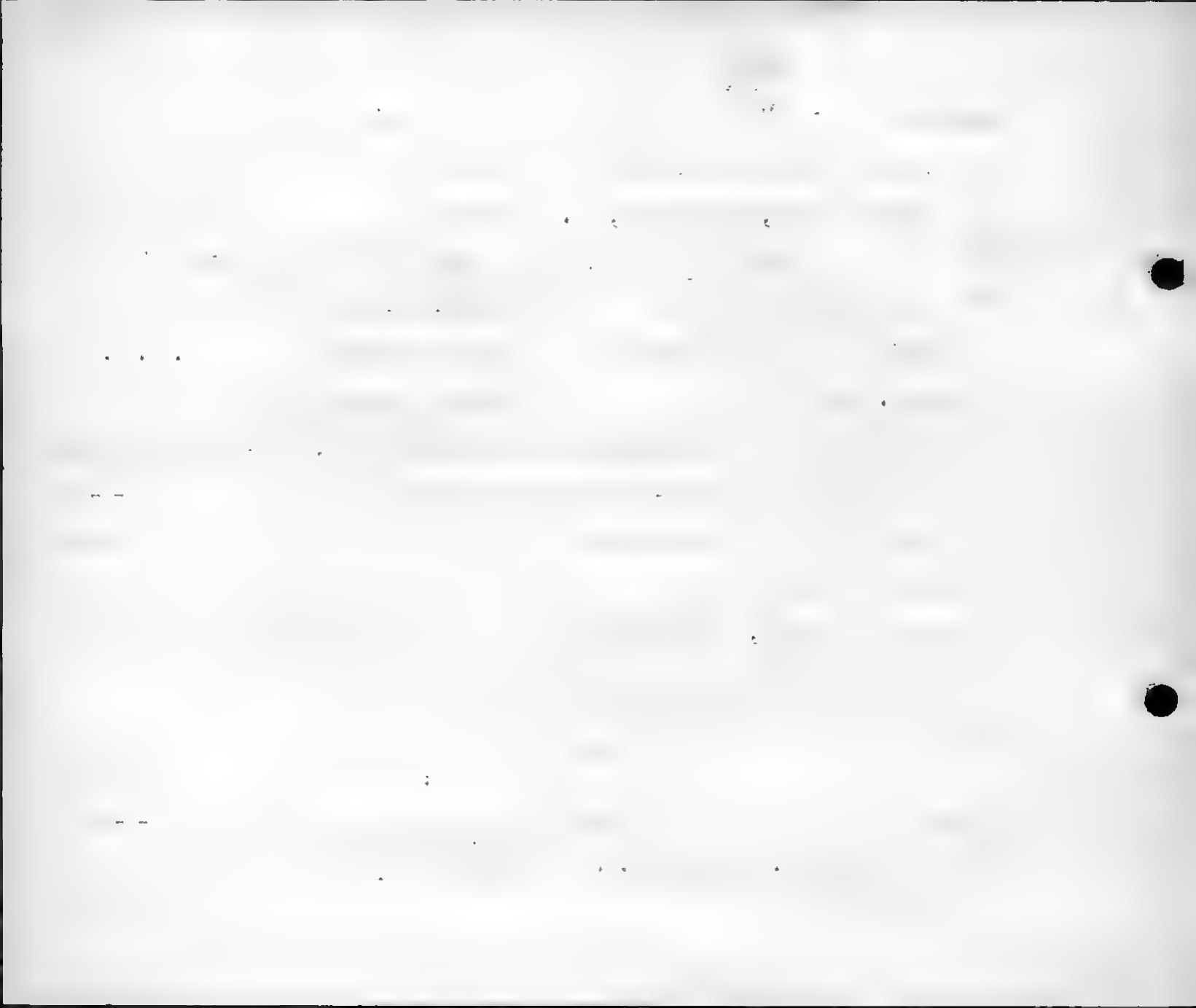
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 1/2 days	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban hospital		e. STREET ADDRESS 4721 N. Chelsea Lane	
3. NAME OF DECEASED (Type or print) First Kathryn Middle Smoot Last DuQuoin		4. DATE OF DEATH Month February Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1884
9. AGE (in years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 75 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Smoot		14. MOTHER'S MAIDEN NAME Minnie Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes-Unknown	
17. INFORMANT John S. DuQuoin (son)		Address same as above #2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 480X DUE TO Pneumonia			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Influenza DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour, a. m. 2:00 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 9 19 60 to Feb 19 19 60 ; that I last saw the deceased alive on 2/19/60 19 60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE D. Joseph Kenrick		DATE SIGNED 2/19/60	
PHYSICIAN'S NAME (Type) DR JOSEPH KENRICK		ADDRESS 6450 Wisc. Ave. Beth, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. RECEIVED BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Fraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

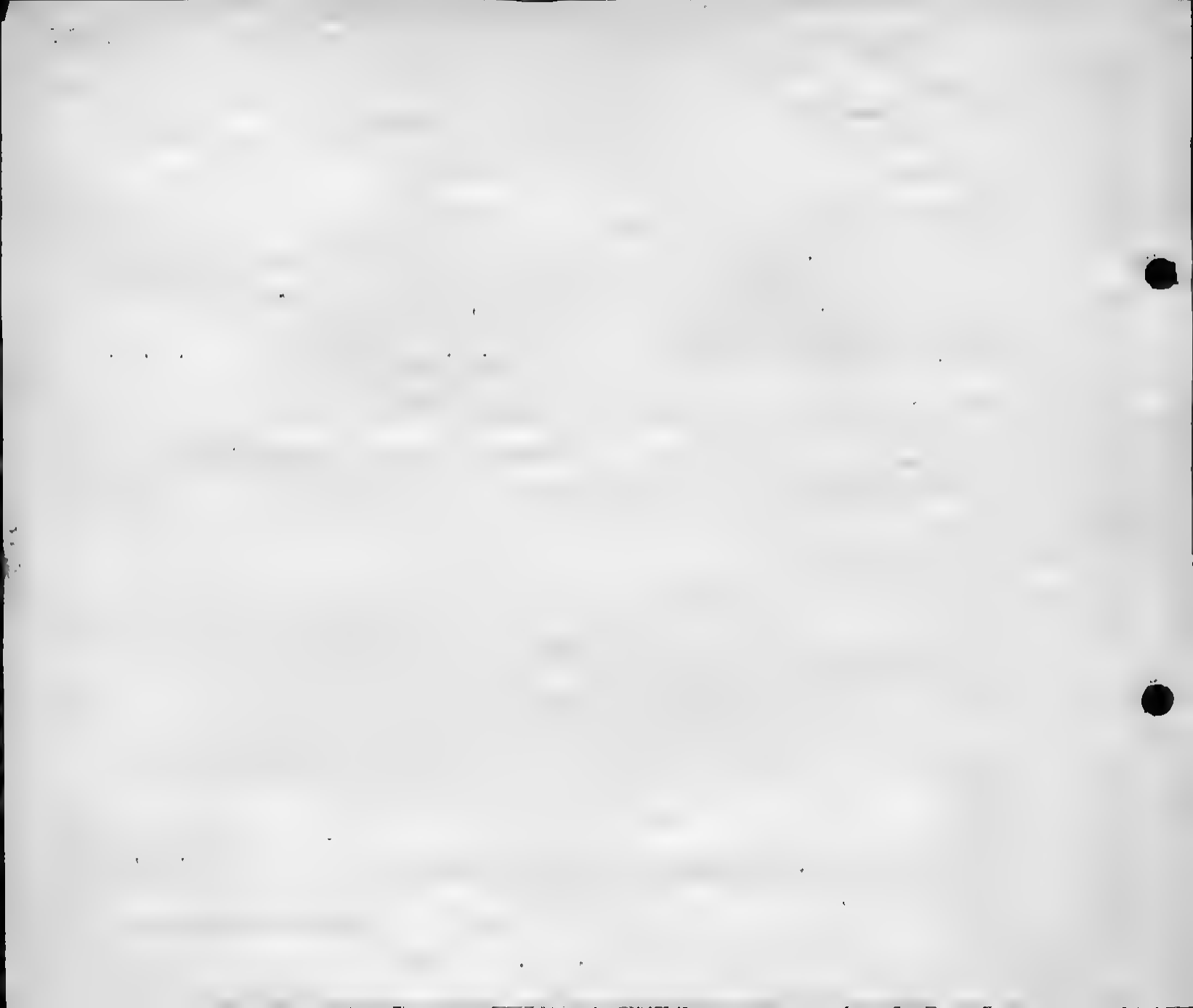
VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02141

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5073 SMITH COURT		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 5073 SMITH COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN H. DYSON		4. DATE OF DEATH FEBRUARY 29 19 60	
5. SEX MALE	6. COLOR OR RACE COL.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPT. GARAGE		10b. KIND OF BUSINESS OR INDUSTRY AUTO	9. AGE (In years last b. day) 52 yrs.
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN H. DYSON		14. MOTHER'S MAIDEN NAME SOPHIE MATTHEWS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Katherine Dyson		Address 5000 River Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED FEB. 29, 1960	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/60	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or country) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR John F. Stewart		24a. REC'D BY REGISTRAR MAR 3 '60	
Address 30 H Street, N.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraye	



2204

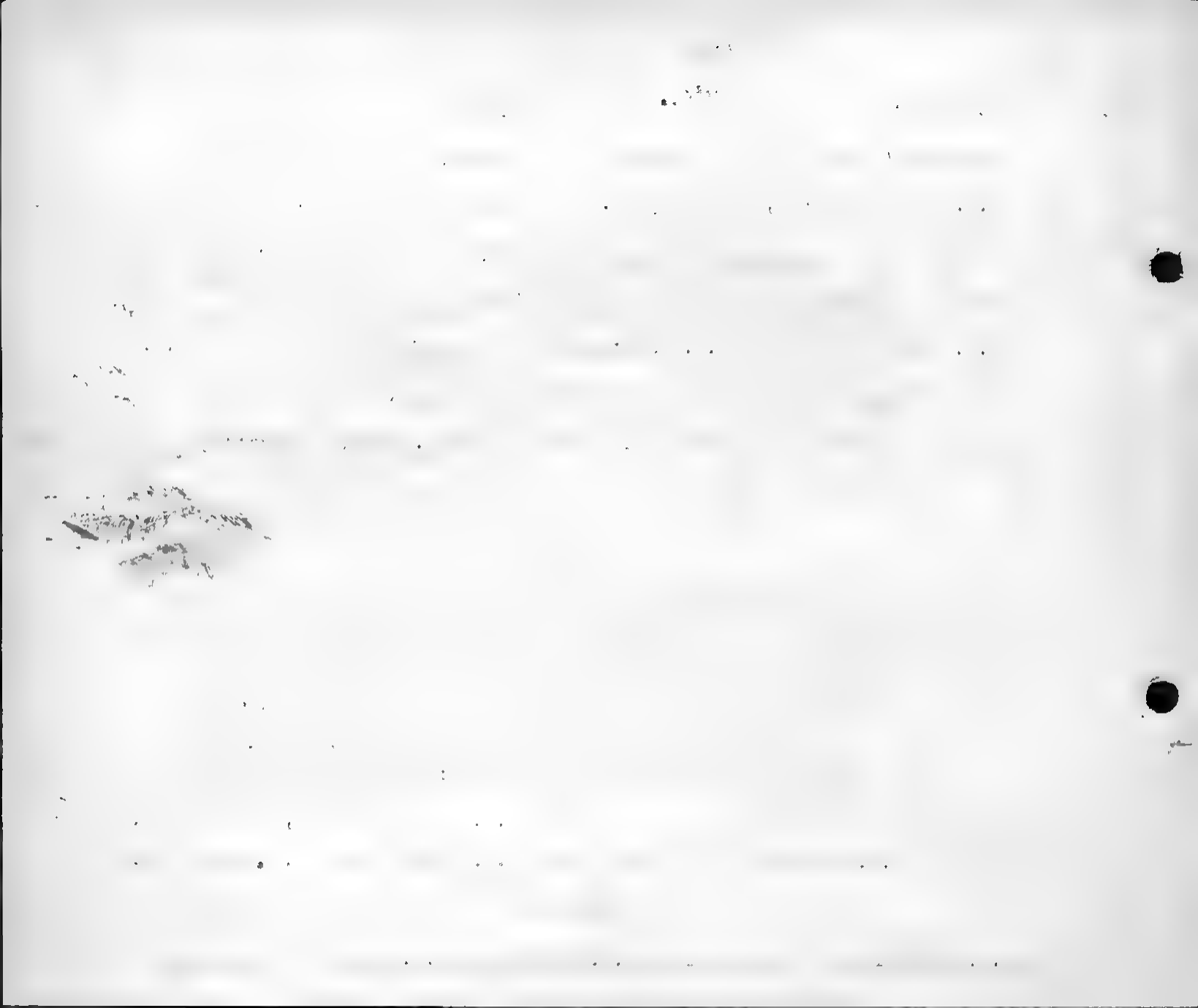
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Florida		b. COUNTY 41	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 4852 Cardinal Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Harould Loyd ELDER		4. DATE OF DEATH Month Day Year February 24 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-30-22		9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wyach ELDER		14. MOTHER'S MAIDEN NAME Ina FULLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 418 36 3117		17. INFORMANT (Wife) Vera I. ELDER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Tumor (metastatic) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma lung DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from 19 February, 1960 , to 24 February, 1960 , that I last saw the deceased alive on 24 February, 1960 , and that death occurred at 8:50A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W.H. Druckemiller		M.D. U.S. Naval Hospital, Bethesda Md. 2-25-60		PHYSICIAN'S NAME (Type) W.H. DRUCKEMILLER CAPT MC USN		U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-60		22c. NAME OF CEMETERY OR CREMATORY Dover Cemetery		22d. LOCATION (City, town, or county) (State) Dover Florida			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber		ADDRESS 1400 Chapin Street N.W. Washington		24a. REC'D BY REGISTRAR D.C. FEB 29 1960		24b. REGISTRAR'S SIGNATURE Carlton S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

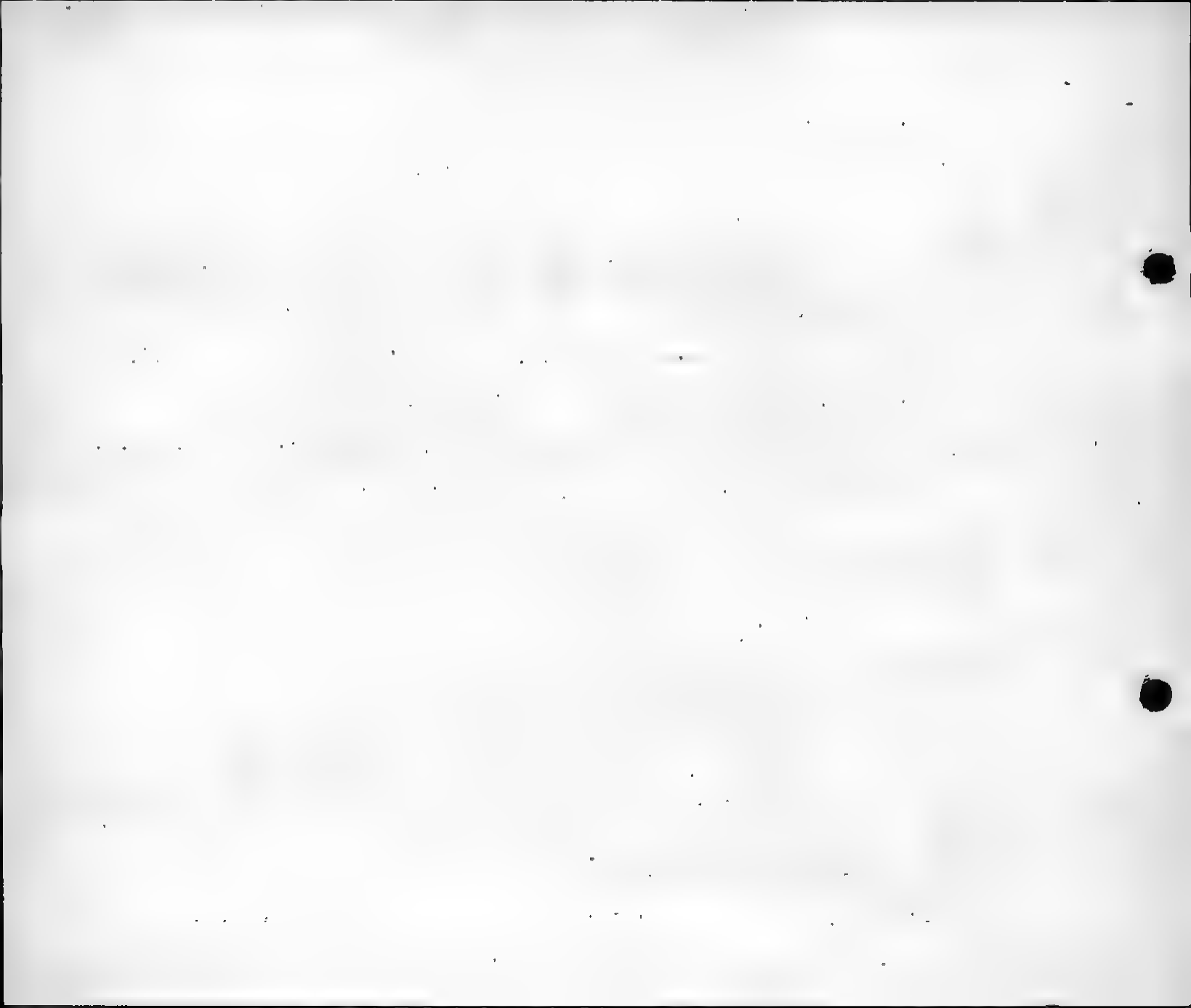
2205

CERTIFICATE OF DEATH

02143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Willis</u> Last <u>Embrey</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/17</u>	
9. AGE (In years last birthday) <u>42</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Dispatcher</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Halto W. Embrey</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Emma May Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>213-12-1955</u>		INFORMANT <u>Slater Mrs. Weaver-Purcellville, Va.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, b. lateral</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe fatty degeneration liver</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 16</u> , 19 <u>60</u> , to <u>Feb 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>60</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Witowski Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Suite 400, 8218 Wisconsin Ave., Bethesda 14, Maryland.</u>					
PHYSICIAN'S NAME (Type) <u>Edward Witowski Jr.</u>		DATE SIGNED <u>2/20/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Round Hill, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



2206 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 8 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6307 TULSA LANE		e. STREET ADDRESS 6307 TULSA LANE	
3 NAME OF DECEASED (Type or print) First ELMER Middle LINWOOD Last EVANS		4. DATE OF DEATH Month FEBRUARY Day 12 Year 1960	
5 SEX MALE	6 COLOR OR RACE CAUCASOID	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1883
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 1 Days 23 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY LIGHTING FIXTURES	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT G. EVANS		14. MOTHER'S MAIDEN NAME EMMA CATLIN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-09-5986 INFORMANT MRS. EVANS Address 6307 TULSA LANE	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 4211 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 3 YEARS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS 15 YEARS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INANITION; INFLUENZA-LIKE ILLNESS BEGAN FEB. 4, 1960			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 4 , 1960, to FEB. 12 , 1960, that I last saw the deceased alive on FEB. 10 , 1960, and that death occurred at 830 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE Joseph D. Connor M.D.		ADDRESS (Street, city or town, state) 7420 Old Georgetown Rd. Bethesda 14 Md.	
PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR, M.D.		DATE SIGNED 2/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/15/1960	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. RECEIVED BY REGISTRAR FEB 15 1960 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

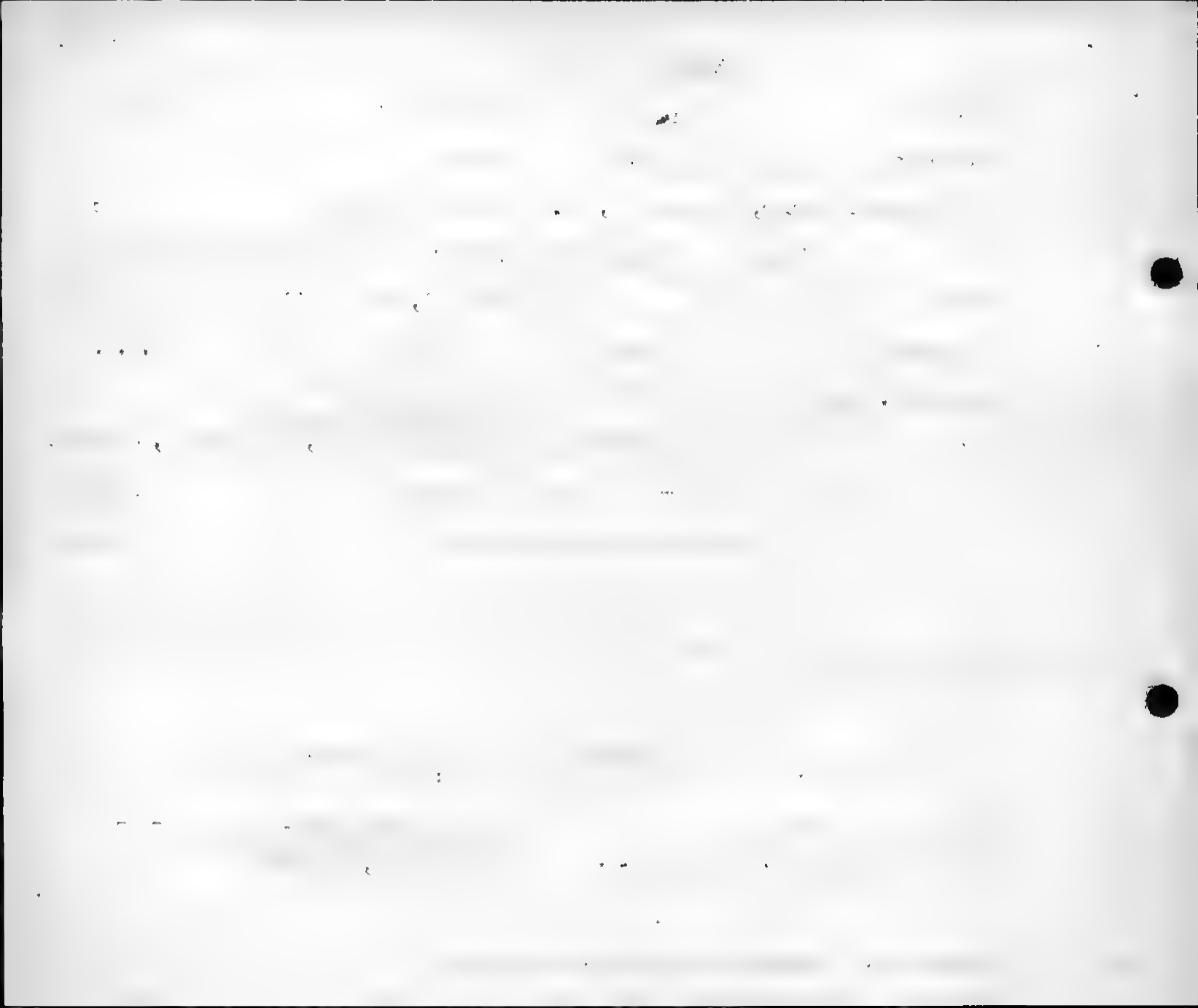
2207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 54 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Hampshire ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Romney d. STREET ADDRESS No street address e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Viola Middle Virginia Last Feller		4. DATE OF DEATH Month February Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1928
9. AGE (In years lost birthday) 31 yrs.		10. IF UNDER 1 YEAR Months 31 Days 19 Hours 19 Min.	11. IF UNDER 24 HRS. Months 31 Days 19 Hours 19 Min.
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Indian O. Sword	
14. MOTHER'S MAIDEN NAME Ethel Kessel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphocytic Leukemia DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 Months	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from December 27, 1959 to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE Charles E. Mengel M.D. The Clinical Center 2-19-60 PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M.D. National Institutes of Health Bethesda 14, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/22/60 22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery 22d. LOCATION (City, town, or county) West Virginia (State) Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR FEB 24 '60 24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filed 2/7 3-1-60 et

2208

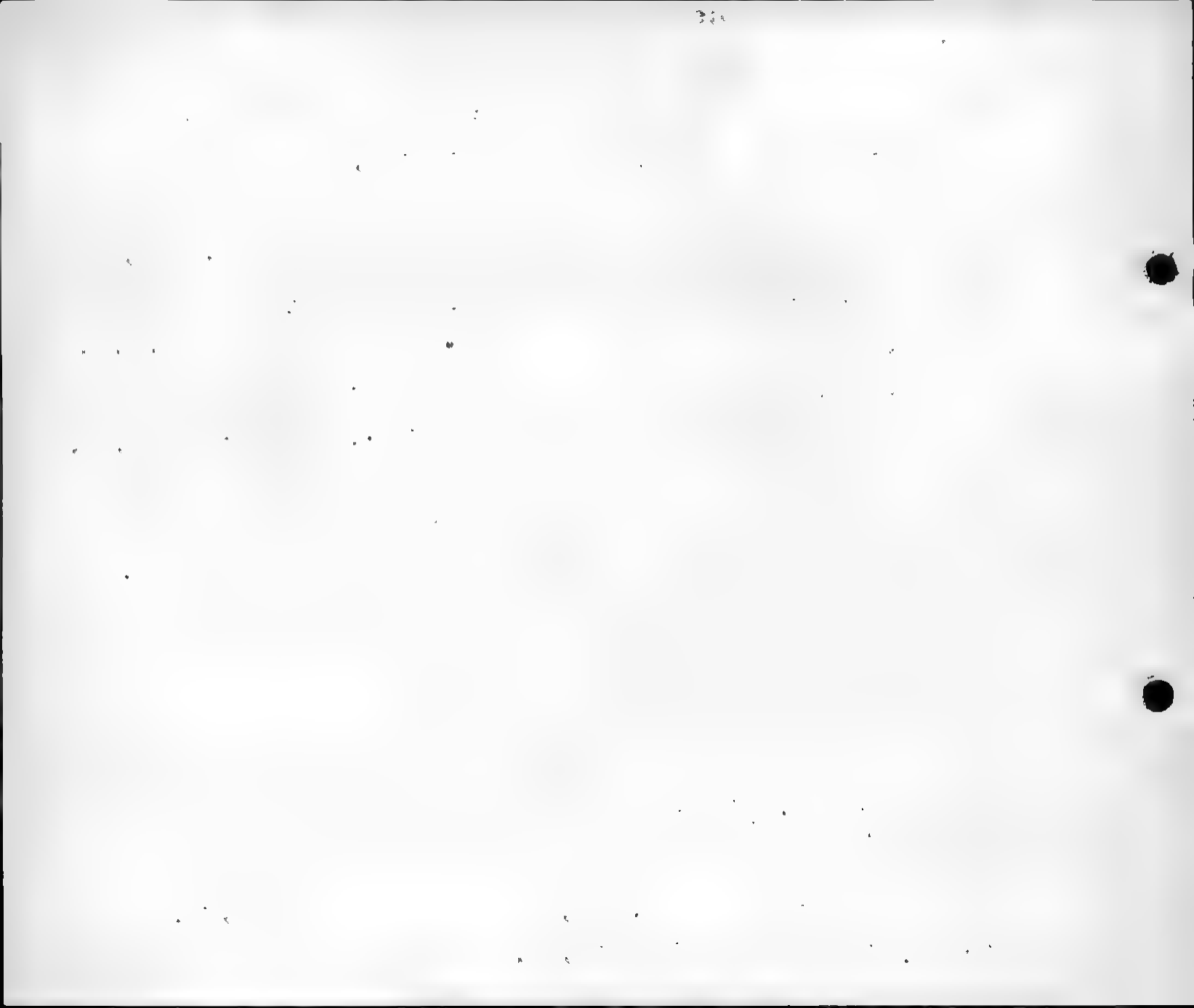
CERTIFICATE OF DEATH

Reg. Dist. No.

02146

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beallsville c. LENGTH OF STAY IN life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beallsville, d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN AUGUSTA FISHER		4. DATE OF DEATH Month Day Year Feb. 7, 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1970/ 1871
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Fisher		14. MOTHER'S MAIDEN NAME Ellen Alice Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT William R. Hood Address Beallsville, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X 446X DUE TO Renal Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis c) 5 years 10 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Feb 1, 1960 , to 7 Feb 1, 1960 , that I last saw the deceased alive on 6 February 1960 , and that death occurred at 2:45 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 11 Feb 60			
ACTUAL SIGNATURE John M. Smith M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion,	22d. LOCATION (City, town, or county) (State) Barnesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE William R. Hood	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 14 Filed 2-27-60 et

2209

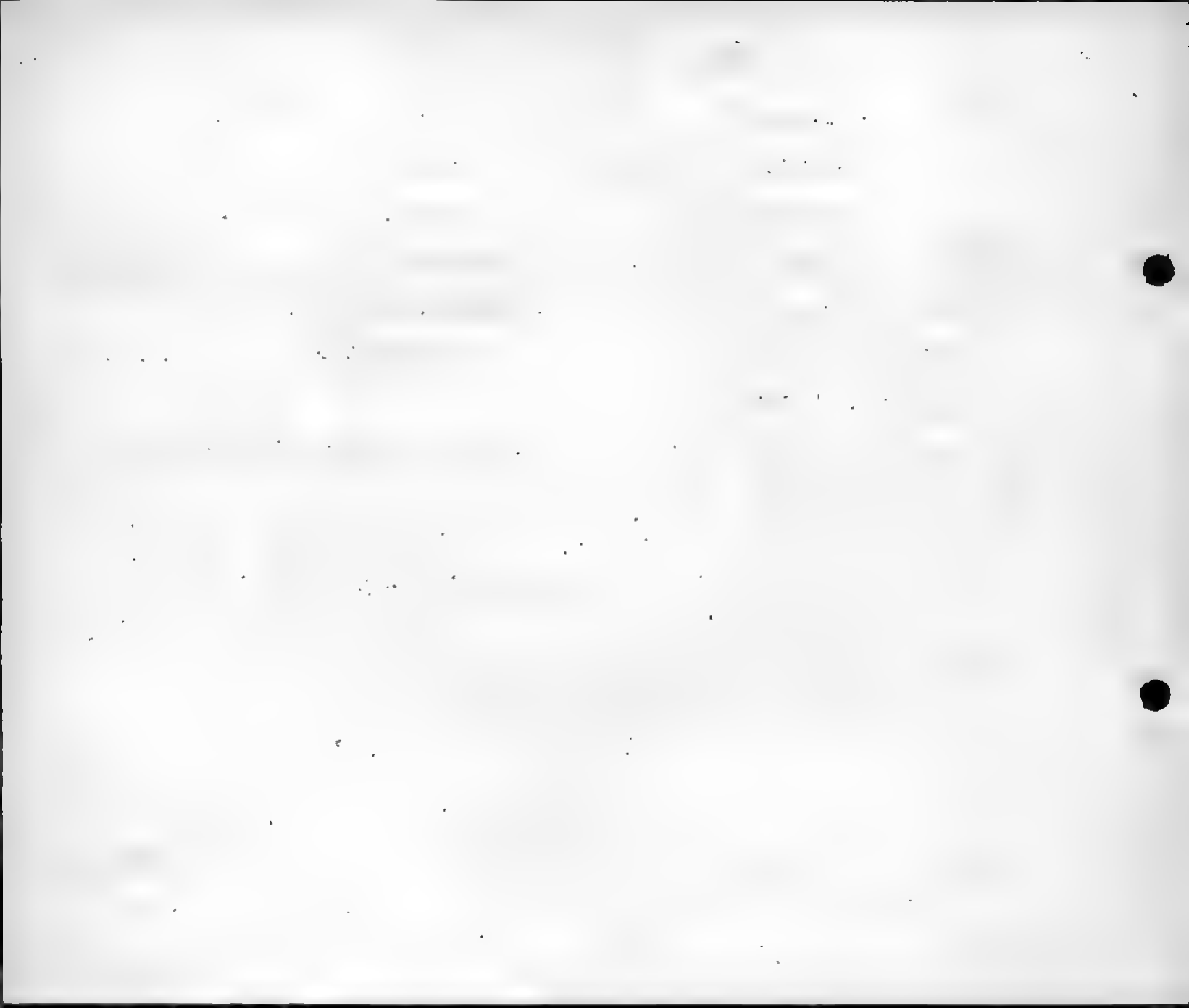
CERTIFICATE OF DEATH

Reg. Dist. No.

02147

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRENE Middle VIRGINIA Last FRAZIER		4. DATE OF DEATH Month 2 Day 23 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1909
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months 4 Days 3 Hours Min 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM R. O'DANIEL		14. MOTHER'S MAIDEN NAME Unknown/ Nutie Goodwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None	
17. INFORMANT HUSBAND		18. ADDRESS CHARLES WESLEY FRAZIER	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 175.0 DUE TO Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Carcinomatosis DUE TO 2 years (c) Papillary Carcinoma of Ovary DUE TO 2 years		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1958, to Feb 23 , 1960, that I last saw the deceased alive on Feb 23 , 1960, and that death occurred at 7:30 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE John C. Murphy		ADDRESS (Street, city or town, state) 1501 EYE ST NW Washington D.C.	
PHYSICIAN'S NAME (Type) JOHN C. MURPHY,		DATE SIGNED 2-24-60	
22a. BURIAL, CREMATION, Burial		22b. DATE THEREOF 2-24-60	
22c. NAME OF CEMETERY OR CREMATORY Montlawn Cemetery		22d. LOCATION (City, town, or county) (State) Wake County, North Car.	
23. FUNERAL DIRECTOR'S SIGNATURE R H Humphreys Funeral Home		24a. REC'D BY REGISTRAR FEB 26 '60	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Collier & House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02148

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SEMINARY ROAD AND SUTTON PLACE		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 7710 EASTERN AVE. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MOE FREIDIN First Middle Last 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/15/1902 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.		4. DATE OF DEATH Feb. 15 1960 Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN 10b. KIND OF BUSINESS OR INDUSTRY HECKMAN PRODUCTS 11. BIRTHPLACE (State or foreign country) NEW YORK 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM FREIDIN 14. MOTHER'S MAIDEN NAME BERTHA UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Frances C. Freidin, 7710 Eastern Ave., NW Washington, D.C. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2-16-60 22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN 22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.		23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th St NW ADDRESS 24a. REC'D BY REGISTRAR FEB 18 '60 DATE 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2210

CERTIFICATE OF DEATH

Reg. Dist. No.

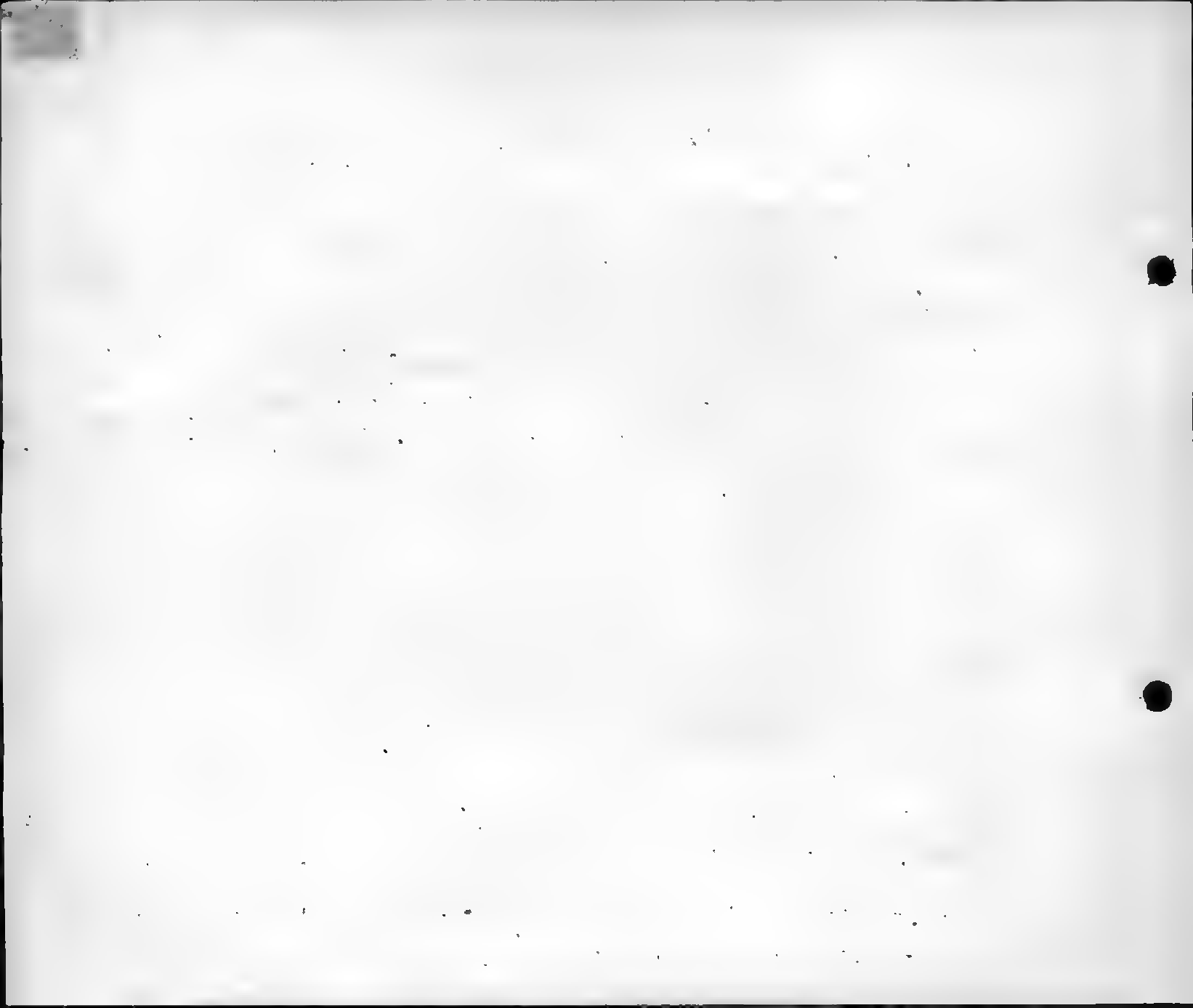
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DETHESDA-</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Margaret Gallagher</u>		4. DATE OF DEATH Month Day Year <u>2 6 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/7/87</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKING</u>	
11c. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Kohlman, Fred</u>		14. MOTHER'S MAIDEN NAME <u>Annie Dever</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertension heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>34 yrs.</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 6</u> , 19 <u>60</u> , to <u>Feb 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>60</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. K. Sanudo</u> M.D.		ADDRESS (Street, city or town, state) <u>13000 GA. AVE.</u> DATE SIGNED <u>2-6-60</u>	
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>		<u>SILVER SPRING MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-60</u>	22c. NAME OF CEMETERY OR CREMATOR <u>St. Francis Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Collins</u> ADDRESS <u>3821-14th St. N.W. DC</u>		24a. REC'D BY REGISTRAR <u>Wash</u> DATE <u>FEB 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1 X
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1 mo.</u>				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>				d. STREET ADDRESS <u>8613 Ewing Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Julius Gertler</u>				4. DATE OF DEATH <u>Feb 25 1960</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-10-1880</u> 9. AGE (in years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Turner (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Montenegro Russia</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Nursing Home Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>Subless</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>2-25-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/26/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL Cem</u>			
22d. LOCATION (City, town, or county) <u>OXON HILL, MD</u>				22e. (State)				22f. (Country)			
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>				ADDRESS <u>4217-9200 PK</u>				24a. REC'D BY REGISTRAR <u>DAVID 29 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				24c. (City, town, or county)				24d. (State)			



2211

CERTIFICATE OF DEATH

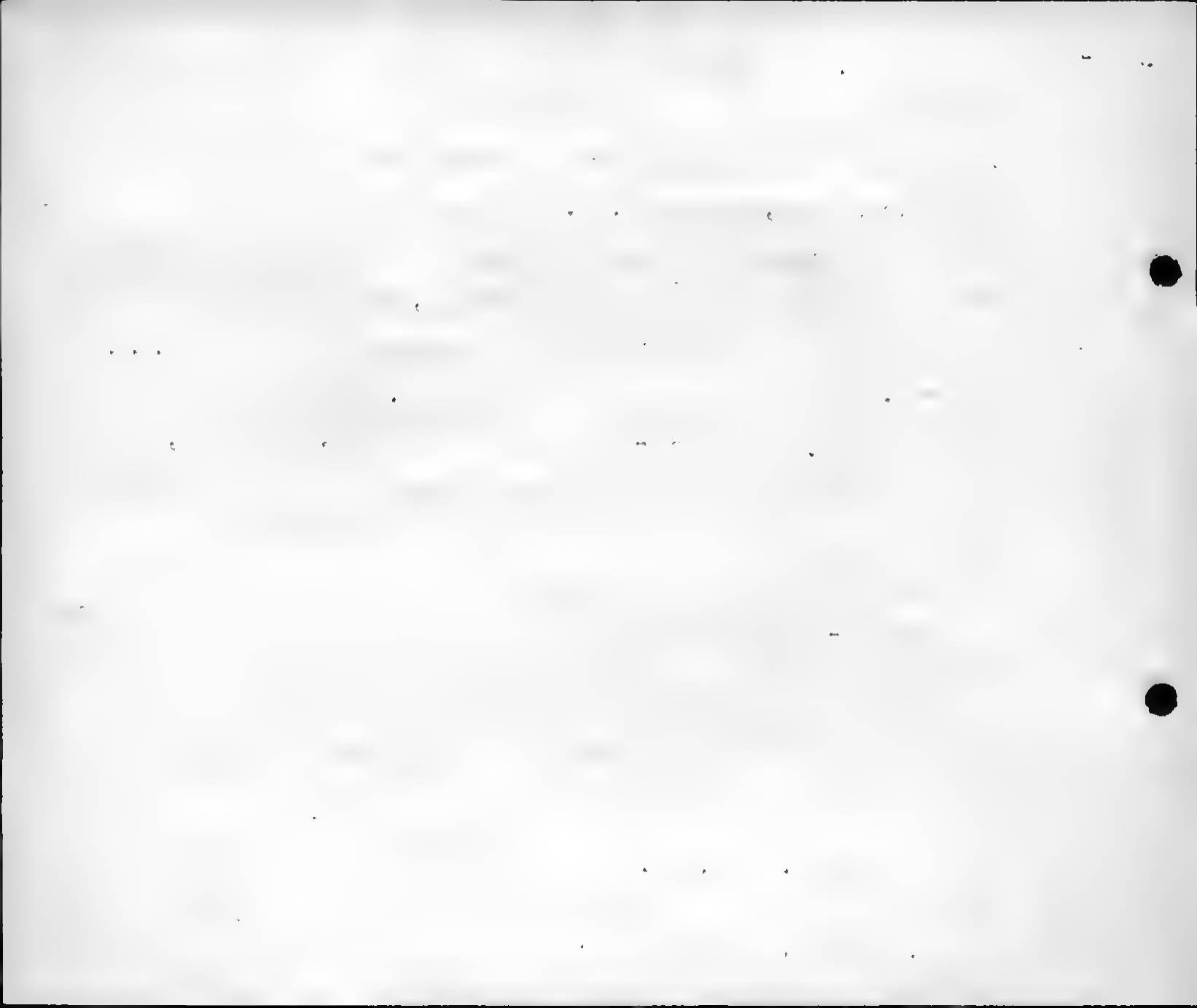
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 111 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Michigan		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 991 South Oxford Road	
3. NAME OF DECEASED (Type or print) First Norman		Middle Clyde		Last Geyer		4. DATE OF DEATH Month February		Day 28	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1892		9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Paper Products		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William F. Geyer				14. MOTHER'S MAIDEN NAME Margaret A. Blakely					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 352-07-1716		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant carcinoid syndrome 229X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho-pneumonia								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home farm factory street office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from November 9, 1959 to February 28, 1960 , that I last saw the deceased alive on February 28, 1960 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland									
ACTUAL SIGNATURE <i>Victor W. Sidel</i>		DATE SIGNED 2/29/60							
PHYSICIAN'S NAME (Type) Victor W. Sidel, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/29/60		22c. NAME OF CEMETERY OR CREMATORY Forrestlawn Cemetery		22d. LOCATION (City town, or county) (State) Detroit, Michigan			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co		ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



Item 18 Film 254
3-10-60 am

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolsville</u>	
c. LENGTH OF STAY IN TB <u>DOA</u>		d. STREET ADDRESS <u>SUBURBAN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PEGGY JANET GIBSON</u>		4. DATE OF DEATH Month Day Year <u>FEB 19 1960</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 20 1960</u>
9. AGE (In years last birthday) <u>0</u> yrs. <u>29</u> Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bethesda Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RONALD GIBSON</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Keen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mattho Sane as Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngo-tracheal bronchitis, acute slight</u> DUE TO <u>Pulmonary edema, marked</u> Conditions, if any, which gave rise to immediate cause (b) <u>Focal hemorrhages, pulmonary parenchymal & plural</u> (c) <u>Mesenteric lymphadenitis</u> DUE TO <u>Visceral Congestion, marked</u> cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Hill</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Freund</u>	
DATE <u>FEB 24 '60</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death (or delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

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CERTIFICATE OF DEATH

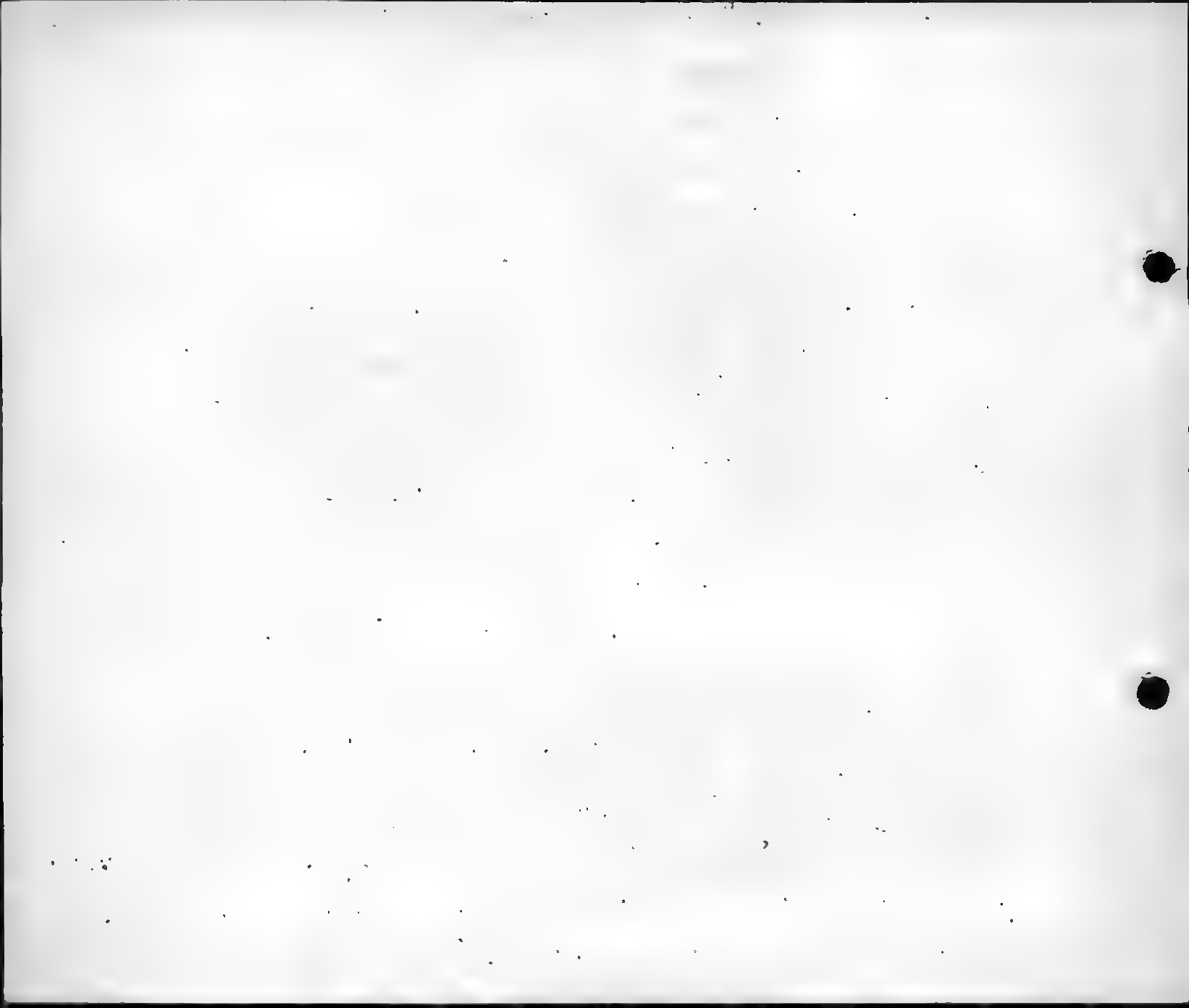
02153

Reg. Dist. No.

2213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Be the sd a</u>		c. LENGTH OF STAY IN 1b <u>2 hrs. 25 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carter</u> Middle <u>S.</u> Last <u>GILLIS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 - 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clergyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Episcopal Church M. H.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Weir Gillis</u>		14. MOTHER'S MAIDEN NAME <u>Carter, Isabelle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes. Army</u>		16. SOCIAL SECURITY NO. <u>Edith Gillis - Fockesville, Md</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last (b) <u>chronic myocardial</u> DUE TO <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1952</u> to <u>Feb 25, 1960</u> , that I last saw the deceased alive on <u>25 Feb</u> , 1960, and that death occurred at <u>7:16 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Lawrence</u> M.D. <u>Dawsonville</u>		ADDRESS (Street, city or town, state) <u>P.O. Box 12, Ark</u> DATE SIGNED <u>2/25/60</u>	
PHYSICIAN'S NAME (Type) <u>John C. Lawrence</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen, Barnesville, Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 7 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2214 CERTIFICATE OF DEATH

02154

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
f. STREET ADDRESS 1801 E. Montgomery Ave		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Aleta Last Graham		4. DATE OF DEATH Month Februaury Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1872
9. AGE (In years (say birthday) yrs) 87		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Andrew J. Ferguson		14. MOTHER'S MAIDEN NAME Famantha Whims	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. James H. Taylor-daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Embolism			
DUE TO 332x			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized ARTERIO SCLEROSIS			
DUE TO AGE			
(c) AGE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1950 to Feb 1960 , that (I) (we) last saw the deceased alive on Feb 1960 , and that death occurred 12 noon from the causes and on the date stated above			
22a. SIGNATURE Leo I. Donovan		22b. DATE SIGNED 2/10/60	
22c. PHYSICIAN'S NAME (Type) Leo I. Donovan, M.D.		22d. ADDRESS 5016 Georgetown Road Bethesda Md	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE C. L. S. K. K.		DATE FEB 11 '60	



2215 CERTIFICATE OF DEATH

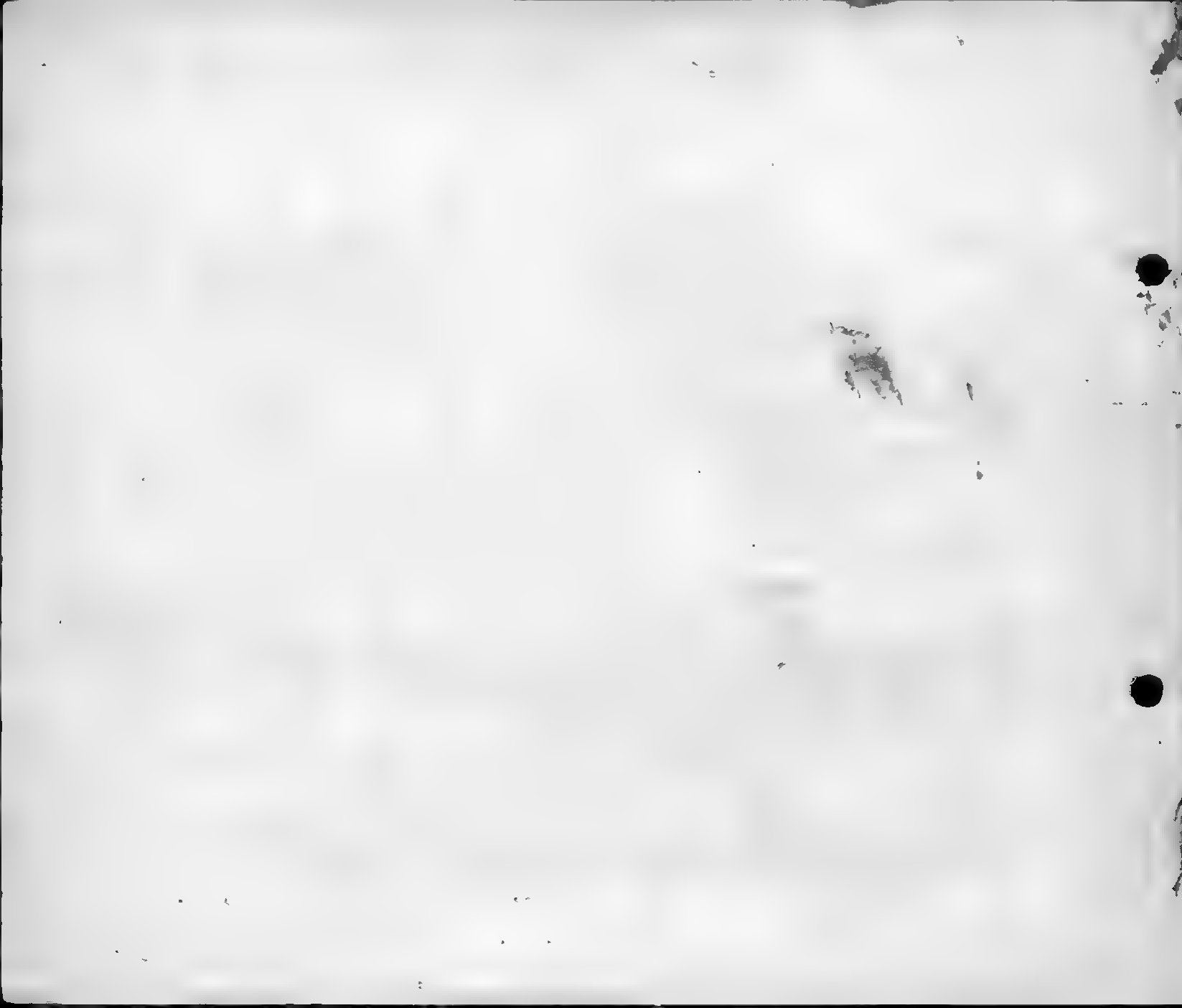
Reg. Dist. No.

02155

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RDI, Silver Spring</u> LENGTH OF STAY IN b. <u>3 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bridford Rest Home, RDI, Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah H</u> First <u>ANN</u> Middle <u>GRAY</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1872</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Daniel Lewis, Nephew</u> Address <u>816 Gilby Ave. Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO <u>Stokes-Adams Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1, 1958</u> to <u>Feb. 12, 1960</u> , that I last saw the deceased alive on <u>Feb. 11, 1960</u> , and that death occurred at <u>3:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson</u> M.D.		ADDRESS (Street, city or town, state) <u>RDI, Gaithersburg, Md.</u> DATE SIGNED <u>2-12-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (city)	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Lunden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2216

CERTIFICATE OF DEATH

02156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's RFD</u>		c. LENGTH OF STAY IN 1b <u>10 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> ^{First} <u>THOMAS</u> ^{Middle} <u>GRIFFIN</u> ^{Last}		4. DATE OF DEATH <u>FEBRUARY</u> ^{Month} <u>28</u> ^{Day} <u>1960</u> ^{Year}	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/79</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Iva Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Anne Byram</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT Address <u>Morgan Lee Griffin Rt. #3 Gaithersburg,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> <u>446X</u> DUE TO (b) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ARTERIOSCLEROTIC KIDNEY DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DECUBITUS ULCERS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>2 MONTHS</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Jan</u> <u>1960</u> to <u>28 Feb</u> <u>1960</u> , that I last saw the deceased alive on <u>28 Feb</u> <u>1960</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Fawcett M.D.</u>		ADDRESS (Street, city or town, state) <u>DAWSONVILLE</u>	
PHYSICIAN'S NAME (Type) <u>JOHN. FAWCETT</u>		DATE SIGNED <u>2/28/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Walker Chapel</u>		22d. LOCATION (City, town or county) (State) <u>Madison, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		ADDRESS <u>Laytonville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove your papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

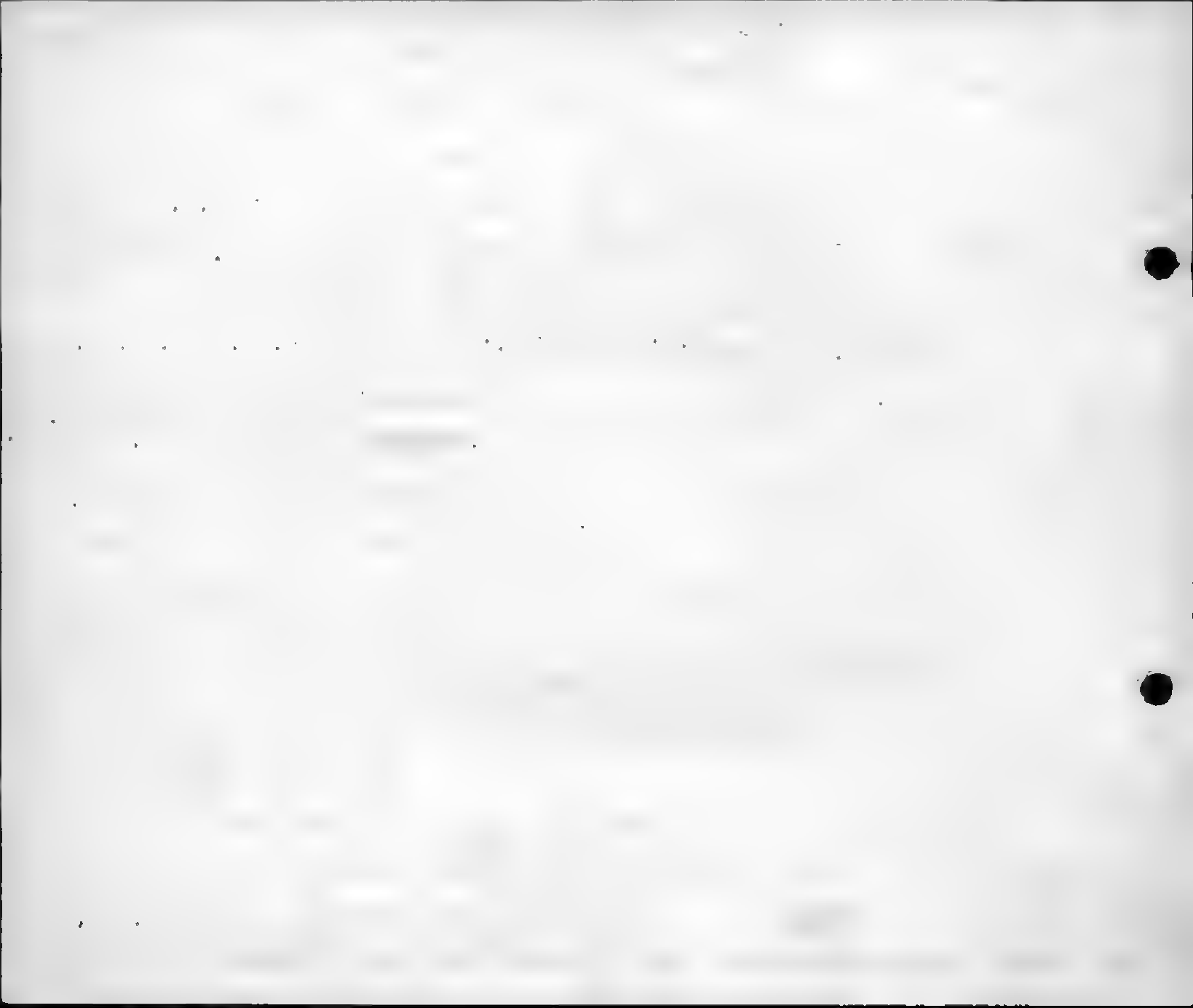
02157

2139

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Clarence Last Griffin		4. DATE OF DEATH Month Feb. Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/1885
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. Paints & Finishing		10b. KIND OF BUSINESS OR INDUSTRY U. S. Senate Bldg.	
13. FATHER'S NAME George M. Griffin		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mary J. Griffin		Address Takoma Pk. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart a fatal exposure to cold (Part II) DUE TO Chronic cardiac renal disease - years DUE TO Valvular heart disease since age 11 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a): 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) fell off back porch 20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18) Home 20c. TIME OF INJURY Month, Day, Year Hour 1 a. m. 26 p. m. 1960 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 9 days years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from 1953 to Feb 4, 1960 that I last saw the deceased alive on Feb. 3, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leland S. Madden M.D. 1831 Yarnum St NE.			
ACTUAL DEATH TIME Leland S. Madden			
PHYSICIAN'S NAME (Type) Leland S. Madden Washington 18 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/6/60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Liffman Co 2901-14th St		24a. REC'D BY REGISTRAR FEB 8 '60	24b. REGISTRAR'S SIGNATURE C. L. S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2217 CERTIFICATE OF DEATH

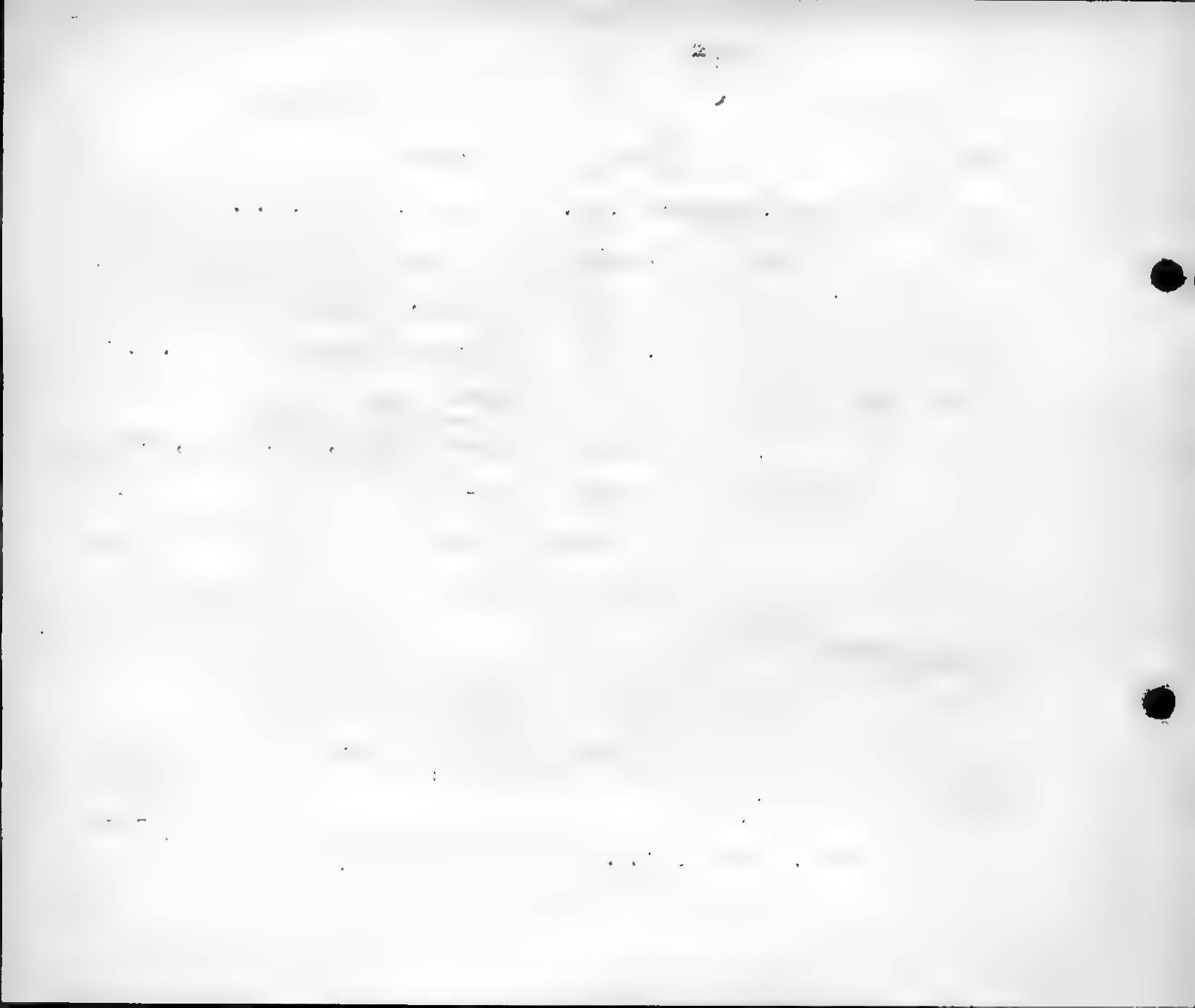
Reg. Dist. No.

02158

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE District of Columbia COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1436 Whittier Place, N.W.	
3. NAME OF DECEASED (Type or print) First Toby Middle Pauline Last Gutwerk		4. DATE OF DEATH Month February Day 24 Year 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1940
9. AGE (In years lost birthday) 19 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 19 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Student) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathan Gutwerk		14. MOTHER'S MAIDEN NAME Sabina Naiman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage into the Mid-Brain 204.3 DUE TO (b) Acute Myelogenous Leukemia Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 27, 1960 to February 24, 1960 that I last saw the deceased alive on February 24, 1960 , and that death occurred at 6:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-24-60			
ACTUAL SIGNATURE Richard C. Mechanic M.D.		The Clinical Center 2-24-60	
PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-25-60	
22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY + SONS - 3501 - 14th St. N.W.		24a. RECEIVED BY REGISTRAR FEB 26 60	
ADDRESS B. DANZANSKY + SONS - 3501 - 14th St. N.W.		24b. REGISTRAR'S SIGNATURE Carlton E. ...	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2140

CERTIFICATE OF DEATH

Reg. Dist. No.

02159

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Laurel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 16x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		e. STREET ADDRESS <u>Crane's Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Stewart</u> First Middle Last <u>T. HALLIDAY</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28, 1904</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Arthur Halliday</u>		14. MOTHER'S MAIDEN NAME <u>Klein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 26, 1960</u> to <u>Feb 12, 1960</u> , that I last saw the deceased alive on <u>Feb 12, 1960</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>1019 University Boulevard</u> DATE SIGNED <u>Feb 14/60</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		<u>Silver Spring Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 17, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walker</u> ADDRESS <u>254 Carroll St. NW.</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '60</u> DATE <u>FEB 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

hours after death

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN

may be retained by the hospital or attending physician.



2218 CERTIFICATE OF DEATH

Reg. Dist. No.

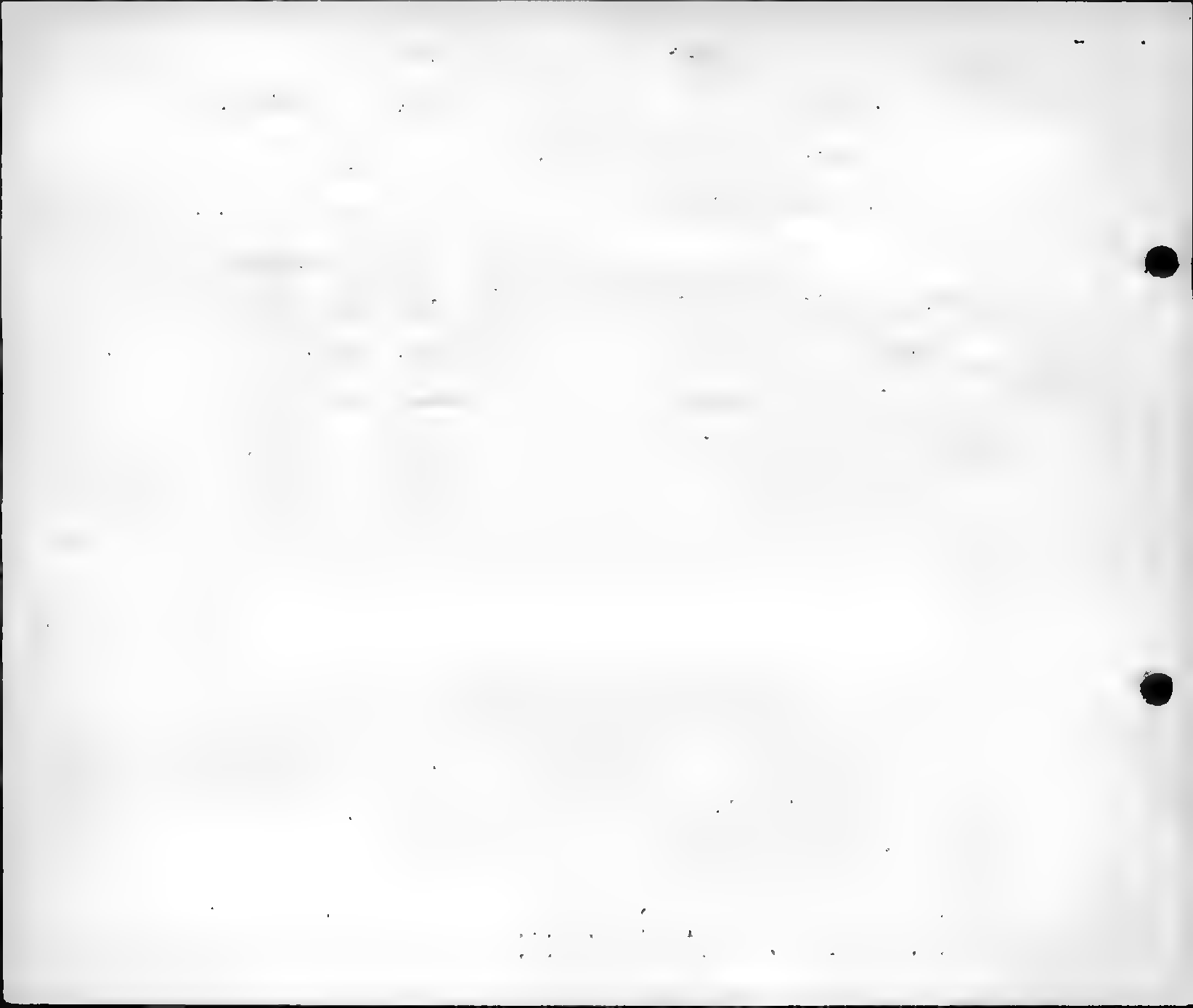
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE District of Columbia ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 5 da 14 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle L Last Harding		4. DATE OF DEATH Month February Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1874
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Wallace		14. MOTHER'S MAIDEN NAME Adelaide Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Son		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days 17 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1943, to Feb. 1 , 1960, that I last saw the deceased alive on Jan. 30 , 1960, and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Karl Dertzbach		ADDRESS (Street, city or town, state) Washington, D.C.	
PHYSICIAN'S NAME (Type) Karl Dertzbach, M.D.		DATE SIGNED 2/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/3/60	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town or county) (State) Leesburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR FEB 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



2219 CERTIFICATE OF DEATH

02161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown-Rural				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Harman				4. DATE OF DEATH Month February Day 16 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1877	
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months 2 Days 17		IF UNDER 24 HRS Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John E. Harman				14. MOTHER'S MAIDEN NAME Elizabeth Best			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
INFORMANT Lester Harman-son-City 13, Rockville Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 hour 15 years 25 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May, 1959 , to 16 Feb 1960 that I last saw the deceased alive on 16 Feb 1960 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Hall				ADDRESS (Street, city or town, state) 615 W. Montg. Ave. Rockville, Md.			
PHYSICIAN'S NAME (Type) W. G. Hall				DATE SIGNED 2/16/60			
22a. BURIAL, CREMATION, REMOVA. (Specify) Burial		22b. DATE THEREOF 2/19/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



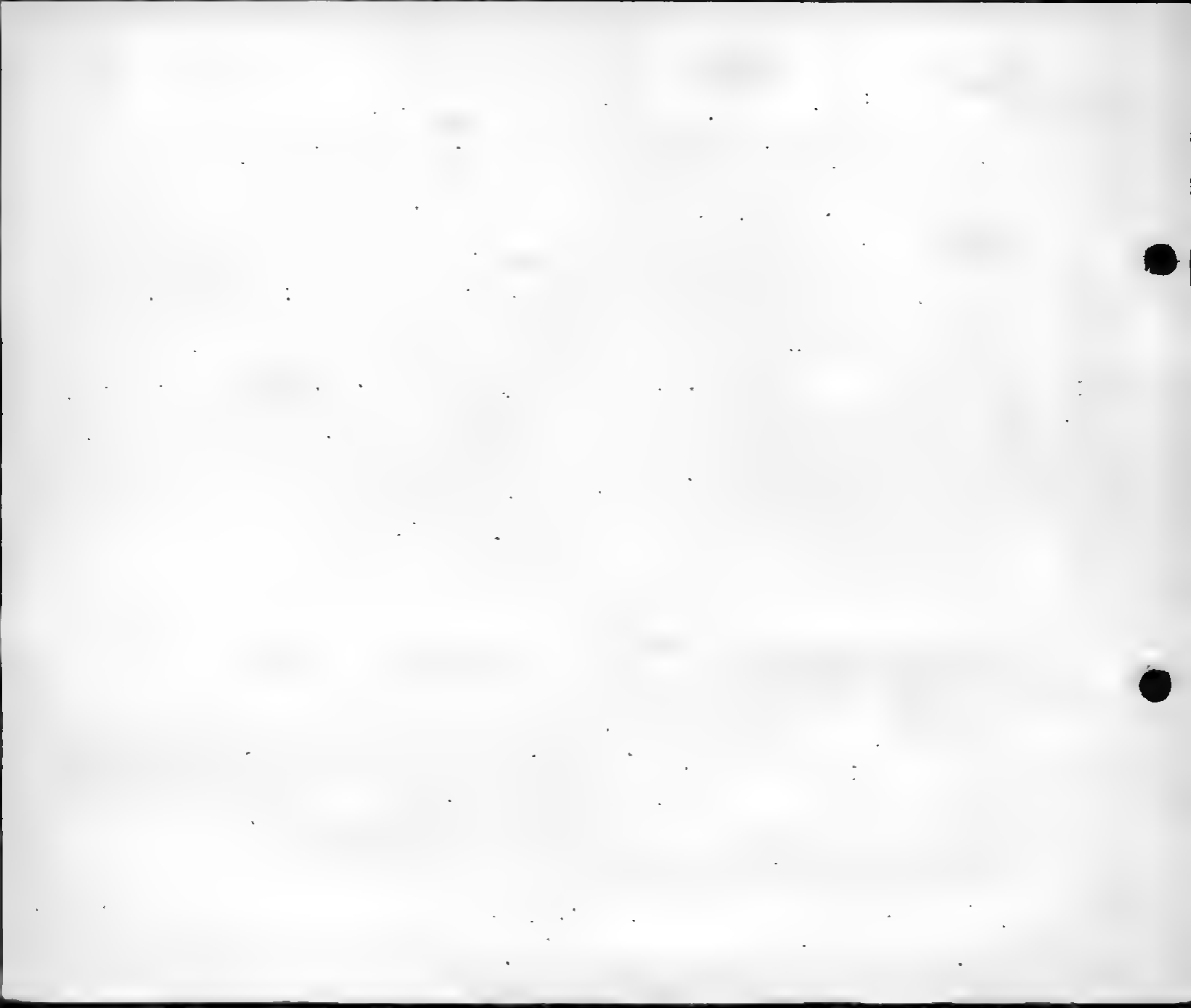
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02162

2120

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Silver Springs	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 8922-GEORGIA AVE.		e. STREET ADDRESS 8922 GEORGIA AVE Silver Sp.	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle LAWRENCE Last HARRINGTON		4. DATE OF DEATH Month FEB Day 18 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NO 23, 1877
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 3 Days 18	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housewife		10b. KIND OF BUSINESS OR INDUSTRY VA	
11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? MONTGOMERY	
13. FATHER'S NAME WM CHICHESTER		14. MOTHER'S MAIDEN NAME MARY ELIZABETH FORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. JOHN F. HARRINGTON - 8922 GEORGIA AVE SPRING	
17. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 155.1 DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 155.1 DUE TO Carcinomatous Primary CA. gall bladder		INTERVAL BETWEEN ONSET AND DEATH 30 days 1 month ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1960 to Feb 18, 1960 that I last saw the deceased alive on Feb 18, 1960 and that death occurred at 8:10 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Harrington M.D.		ADDRESS (Street, city or town, state) 3810-12 NE DATE SIGNED	
PHYSICIAN'S NAME (Type) John F. HARRINGTON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/22/60	22c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CEM.	22d. LOCATION (City, town, or county) (State) ALEXANDER VA
23. FUNERAL DIRECTOR'S SIGNATURE Anthony Haddon - 3831 - GA. AVE		24a. REC'D BY REGISTRAR DATE FEB 24 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hume



2141

CERTIFICATE OF DEATH

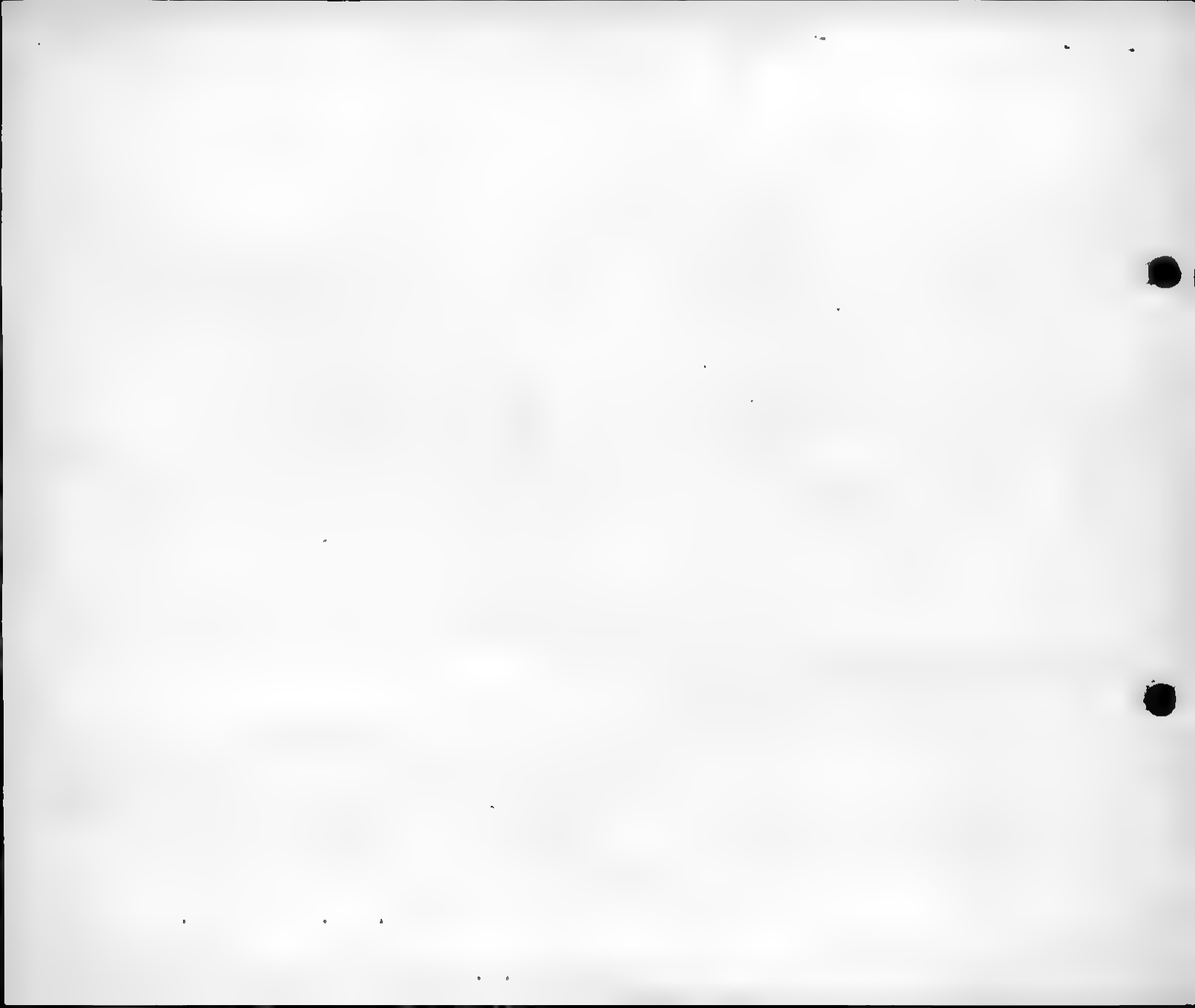
02163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				c. LENGTH OF STAY IN lb <i>40 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery Memorial Hospital</i>				d. STREET ADDRESS <i>201-14th St. N.W.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Anna Margaret Harris</i>				4. DATE OF DEATH Month Day Year <i>Feb. 1 1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-27-74</i>	9. AGE (In years lost birthday) <i>85 yrs</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>A. F. +</i>				14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Mason</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>2-2-4-2-1-1-1-1</i>		INFORMANT <i>W. J. H. +</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Failure</i> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <i>one week</i> <i>two months</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Feb 1</i> , 19 <i>53</i> , to <i>Feb 1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb 1</i> , 19 <i>60</i> , and that death occurred at <i>12:22 PM</i> , from the causes and on the date stated above.							
MEDICAL SIGNATURE <i>Robert A. Hare</i>				ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>			
PHYSICIAN'S NAME (Type) <i>Robert A. Hare M.D.</i>				DATE SIGNED <i>2/1/60</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>2/4/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Ft. Myer, Va.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>SAHines Co</i>				24a. REC'D BY REGISTRAR <i>2901-14th St N.W.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	
DATE <i>FEB 2 '60</i>				ADDRESS <i>Washington 9, D.C.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2220

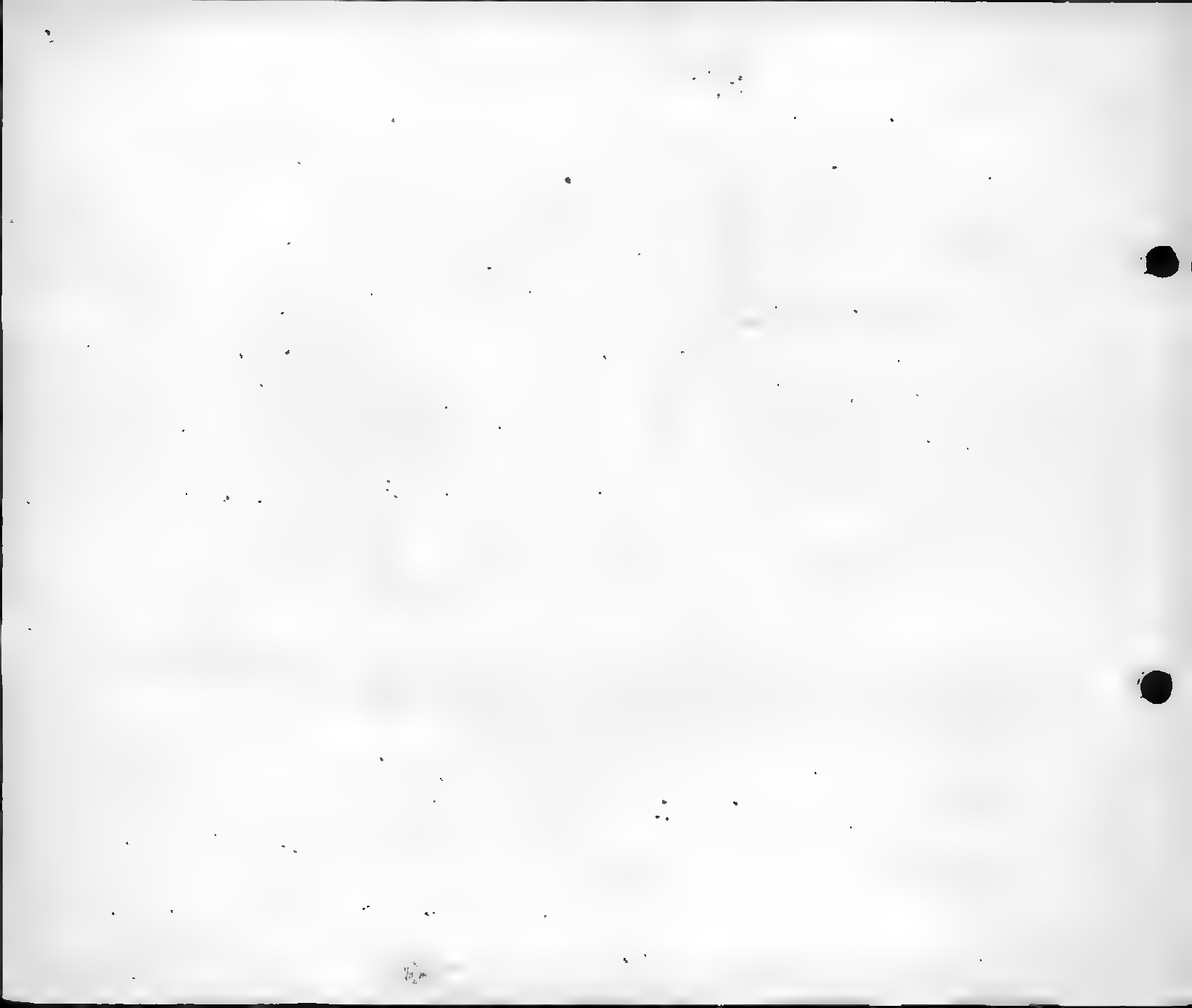
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Chas. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14571 Coleville Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARLEA SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>SADYE MADDOX HAYDEN</u>		4. DATE OF DEATH Month Day Year <u>Feb 15 1960</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2-1886</u>
9 AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>CHARLES CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN W. MADDOX</u>		14. MOTHER'S MAIDEN NAME <u>ELLA SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>L. Edwin Hayden</u>		Address <u>9808 Parkwood Dr. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15-60</u> to <u>2-15-60</u> , that I last saw the deceased alive on <u>2-15-60</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>1819 Semmons Rd 2-15-60</u> PHYSICIAN'S NAME (Type) <u>Arthur L. Hanna</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace's Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Alton Chas. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		24a. REC'D BY REGISTRAR <u>1661 Good Hope Rd</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		DATE <u>FEB 17 1960</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2179

02165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>304 N. Adams St. Apt. 160</u>		e. STREET ADDRESS <u>304 N. Adams St. apt 160</u>	
3. NAME OF DECEASED (Type or print) <u>Sherry Ann Henderson</u>		4. DATE OF DEATH <u>Feb 21 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-1957</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Howard Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Ruth Roney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Howard Henderson (father)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epileptic Seizure</u> 351X DUE TO (b) <u>Cerebral palsy</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>life</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-21-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>2/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Macon, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>FEB 24 1960</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Robert S. Plana</u>	



2221
CERTIFICATE OF DEATH

Reg. Dist. No. 12166

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDNOR</u>		c. LENGTH OF STAY IN 1b <u>1 MON. 3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont Farm Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Otto. Theodore Herxberger</u>		4. DATE OF DEATH <u>2 13 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1860</u>
9. AGE (In years last birthday) <u>99</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Elizabeth G. Laughton</u>		<u>#104-Rainier Ave. Mt. Rainier, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>Chronic pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Wk.</u> <u>Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/10, 1960</u> to <u>2/13, 1960</u> , that I last saw the deceased alive on <u>2/7, 1960</u> , and that death occurred at <u>5:01 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Ligon</u>		ADDRESS (Street, city or town, state) <u>Jandy Spring, Md.</u> DATE SIGNED <u>2/13/60</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Ligon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		24. REC'D BY REGISTRAR <u>md.</u> DATE <u>FEB 17 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



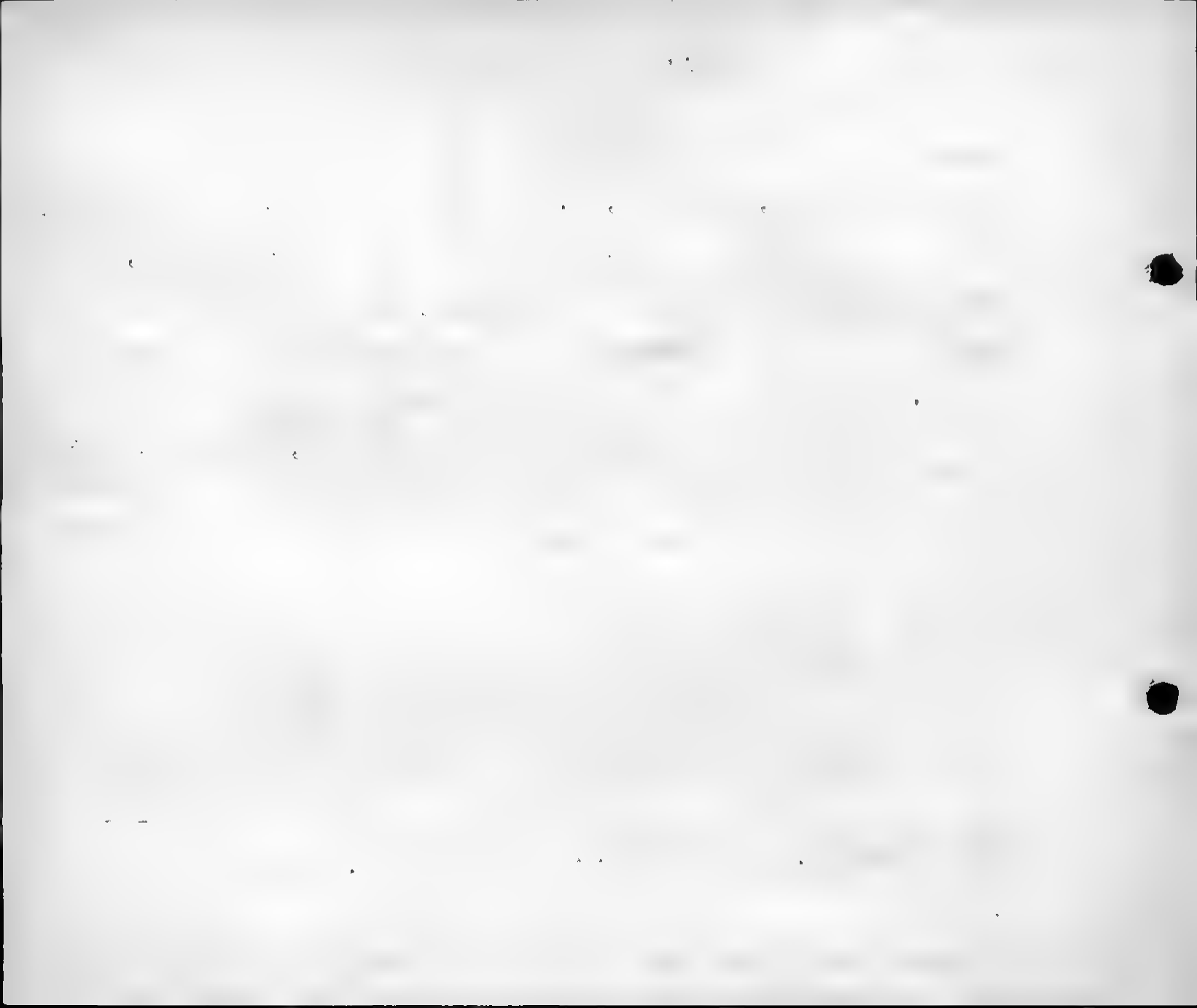
2222 CERTIFICATE OF DEATH

02167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE West Virginia b. COUNTY Beckley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beckley	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route # 3, Box 91	
3. NAME OF DECEASED (Type or print) First Martha Middle Eleanor Last Hickman		4. DATE OF DEATH Month February Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1910
9. AGE (In years lost birthday) 49 yrs.		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stan H. Downey		14. MOTHER'S MAIDEN NAME Ada Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Cervix DUE TO (c) 2 Years		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 8, 19 60 to February 26, 19 60 that I last saw the deceased alive on February 26, 19 60 , and that death occurred at 6:05A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Beckley W. Va. DATE SIGNED 2-26-60			
ACTUAL SIGNATURE Edward D. McLaughlin M.D.		The Clinical Center	
PHYSICIAN'S NAME (Type) EDWARD D. McLAUGHLIN, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2-27-60	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Beckley W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Frojen Funeral Home Inc ADDRESS 389 P. Hill Wash D.C.		24a. REC'D BY REGISTRAR DATE MAR 3 '60	24b. REGISTRAR'S SIGNATURE Charles S. Hanna

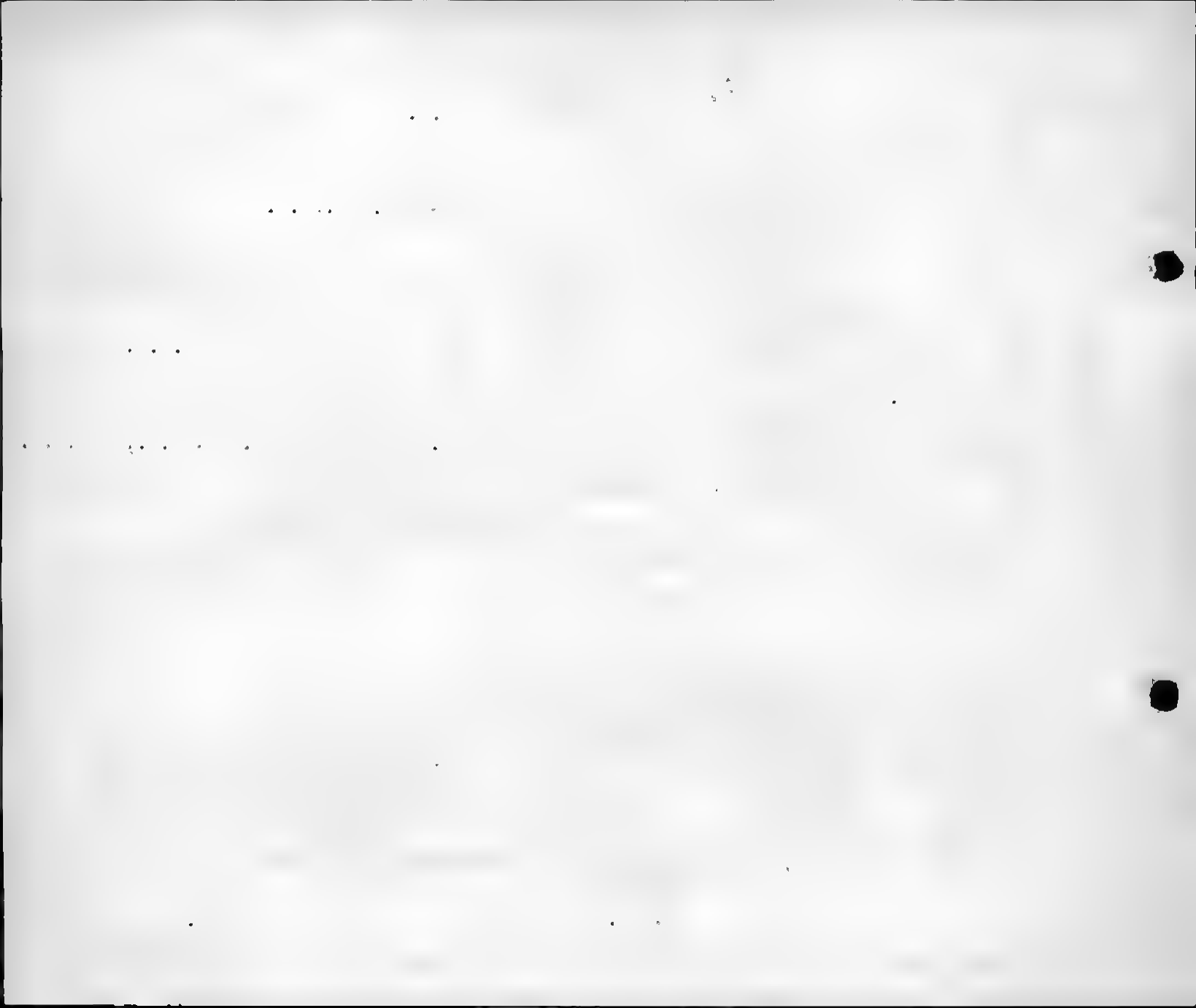
2



2170 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b #3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		e. STREET ADDRESS 1217-30th St., N.W., D.C.	
3. NAME OF DECEASED (Type or print) First William John Middle Hill Last		4. DATE OF DEATH Month February Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 4, 1879
9. AGE (In years and birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Print Pressman		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Hill		14. MOTHER'S MAIDEN NAME Mary Anne Drew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ethel J. Hill, 1217-30th St., N.W., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension 340.3 DUE TO Infection, location undetermined, possible (b) meningitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26, 1960 to February 2, 1960 , that I last saw the deceased alive on February 2, 1960 , and that death occurred at 6:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau, M.D.		ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED Feb 2, 1960	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/60	
22c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home Wash. D.C.		ADDRESS 5703 Wisconsin	
24a. REC'D BY REGISTRAR FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



2223 CERTIFICATE OF DEATH

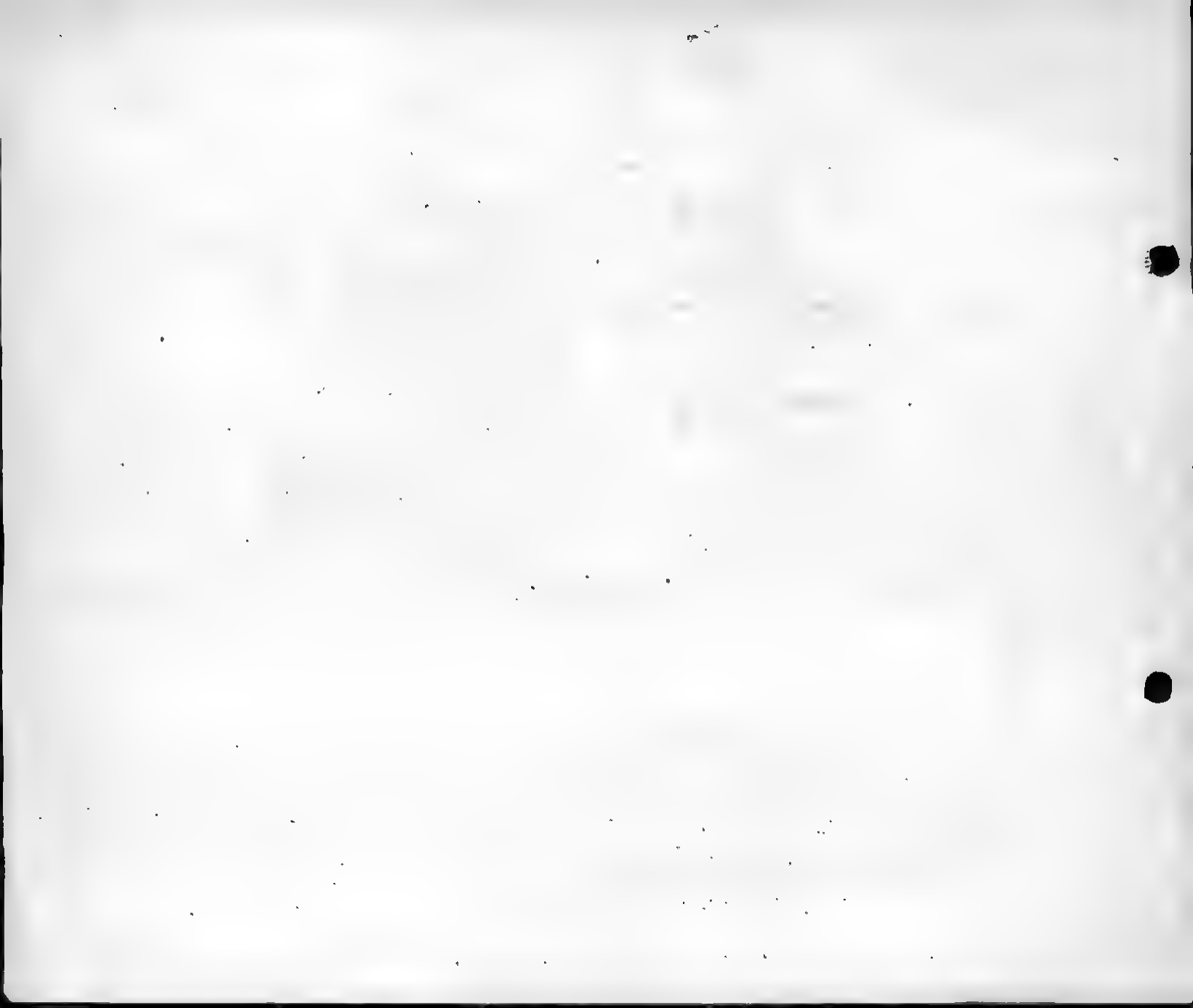
Reg. Dist. No.

02169

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle M. Hilton Last Kensington		4. DATE OF DEATH Month February Day 14 Year 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870
9. AGE (in years lost birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Bohrer		14. MOTHER'S MAIDEN NAME Louisa R. Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO None	
17. INFORMANT William Griffin		Address Maple View Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Capital Accidents Accident DUE TO Hypertension in Cerebral Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10 , 1960, to FEB 14 , 1960, that I last saw the deceased alive on FEB 14 , 1960, and that death occurred at 10:00 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE P. F. Andrews M.D.		ADDRESS (Street, city or town, state) 4201 Fessenden St. N.W. Wash. D.C.	
PHYSICIAN'S NAME (Type) P. F. ANDREWS		DATE SIGNED Feb 17, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 17, 1960	22c. NAME OF CEMETERY OR CREMATORY Damascus Cemetery	22d. LOCATION (City, town, or county) (State) Damascus, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE FEB 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2224 CERTIFICATE OF DEATH

Reg. Dist. No.

02170

Page 4

24 hours after death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

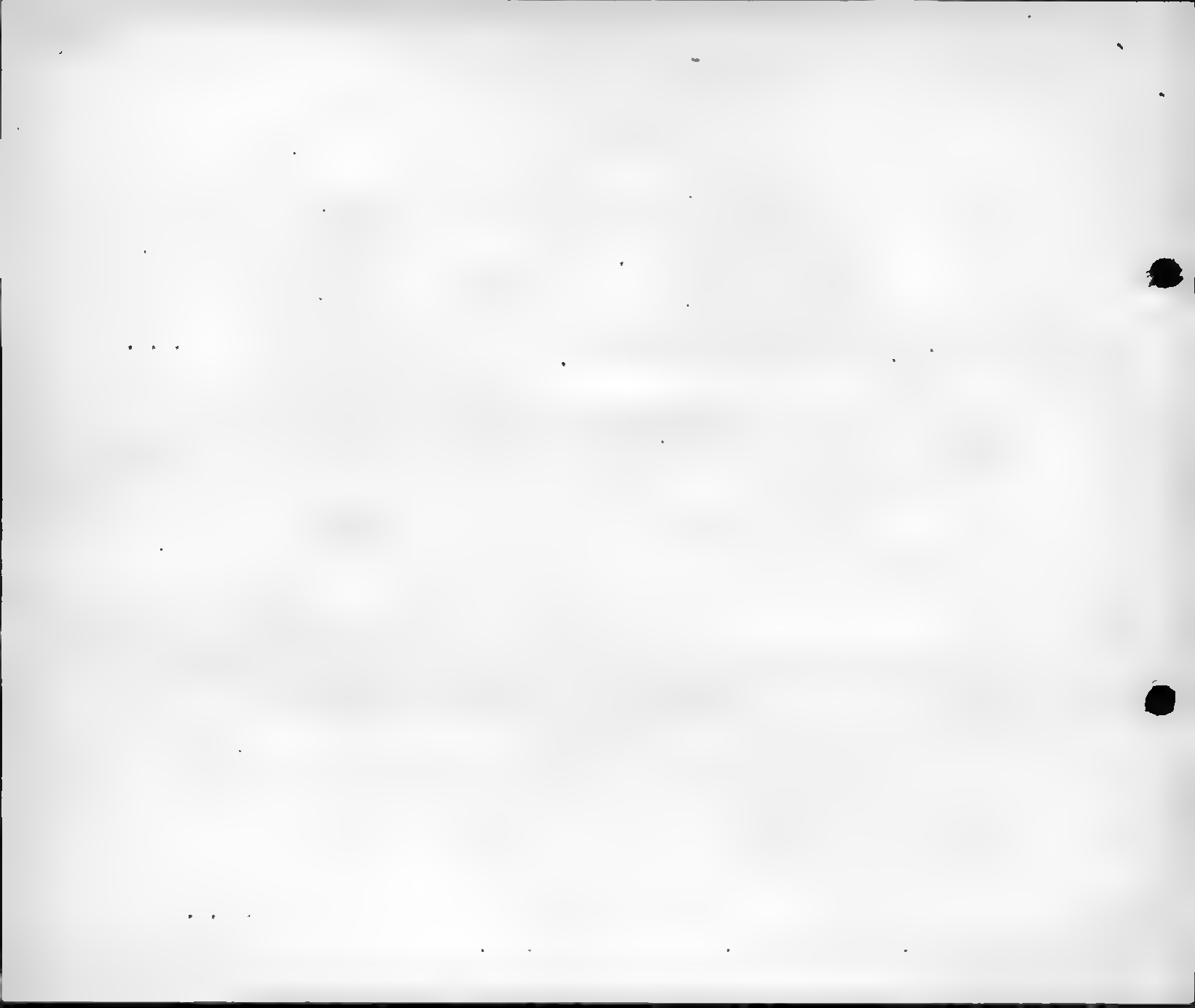
VS A15 (4)
15M 9/58

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDNOR M.D.</u>				c. LENGTH OF STAY IN 1b <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BEIMONT NURSING Home</u>				e. STREET ADDRESS <u>610 Bonifant St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Holloway</u> JOHN J. HOLLOWAY				4. DATE OF DEATH <u>2</u> <u>8</u> <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/68</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN, (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Singer Sewing Machine Co.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>399-20-1745A</u>			
17. INFORMANT <u>Claire Jay Belmont hem.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/6</u> <u>1959</u> to <u>3/8</u> <u>1960</u> , that I last saw the deceased alive on <u>2/7</u> <u>1960</u> , and that death occurred on <u>4:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Logan</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>2/8/60</u>			
PHYSICIAN'S NAME (Type) <u>C. H. Logan</u>							
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENNWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Giska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

370

1



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

2171

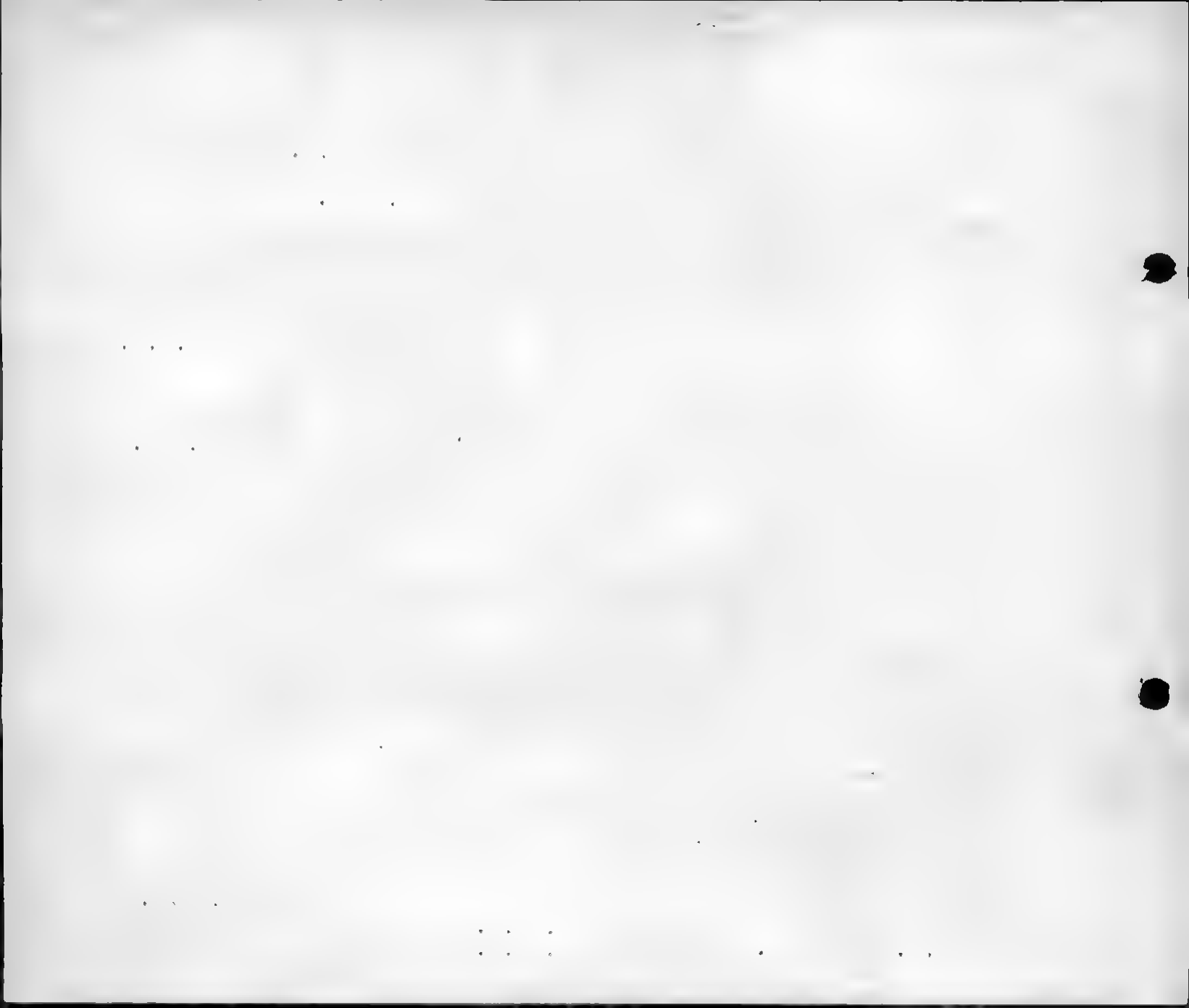
2171

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02171

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 47x- d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1405 G St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HATTIE MARY HOOVER				4. DATE OF DEATH Month Day Year FEB 7 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/13/71	
9. AGE (in years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min. 15 Yrs		11. IF UNDER 24 HRS Months Days Hours Min. 15 Yrs		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME William Osborne				14. MOTHER'S MAIDEN NAME Ella Flynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT James O. Hoover		18. ADDRESS 5705 Maiden Lane Bethesda, Md.	
1B CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized ARTERIOSCLEROSIS (c) AGE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 Days INTERVAL BETWEEN ONSET AND DEATH 15 Yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1958 to Jan 6 1960 , that (I) (we) last saw the deceased alive on Jan 4 1960 , and that death occurred at 12:59 AM from the causes and on the date stated above							
22a. SIGNATURE Leo I Donovan M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) LEO I DONOVAN M.D.				22d. ADDRESS 2016 GEORGETOWN RD BETHESDA 14 MD			
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 2/9/60		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION



2225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>1 da</u>		d. STREET ADDRESS <u>5419 Burding Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Horst</u> Last <u>Horst</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 4, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Sara Linesay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>George S. Smith-Item #2-Son-in-law</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>congestive heart failure, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost <u>stroke of left side, rupture of left ventricle</u> DUE TO <u>myocardial infarction (cor. occlusion)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heartitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1</u> 19 <u>40</u> to <u>2/1</u> 19 <u>60</u> that I last saw the deceased alive on <u>2-1</u> 19 <u>60</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gilbert B. Rude</u> M.D.		ADDRESS (Street, city or town, state) <u>3900 Military Rd N.W. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Gilbert B. Rude</u>		DATE SIGNED <u>2/1/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0256 2-19-60 et

CERTIFICATE OF DEATH

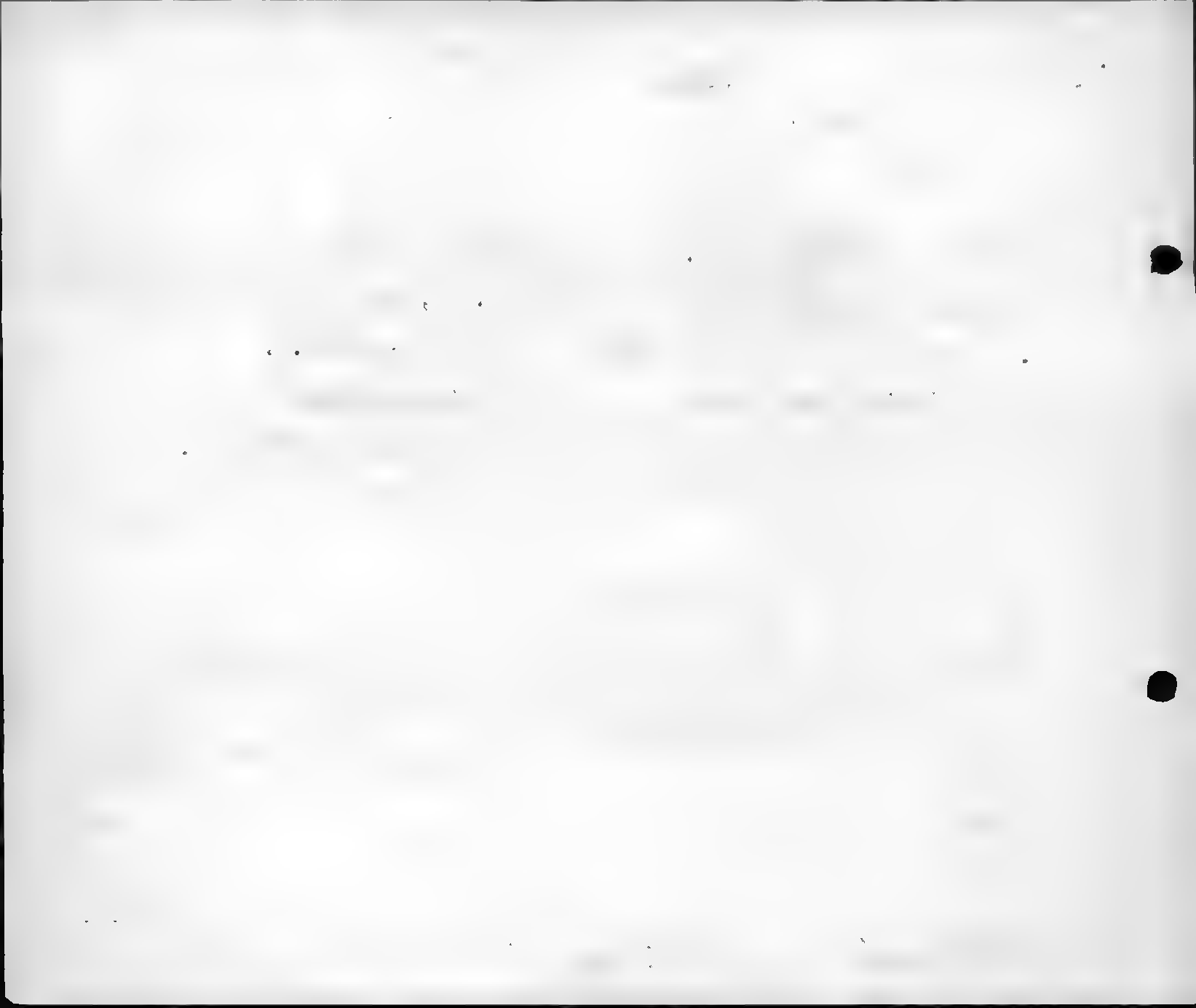
Reg. Dist. No.

02173

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		d. STREET ADDRESS "Mount Airy"	
3. NAME OF DECEASED (Type or print) FLOYD E. HUNTLEY		4. DATE OF DEATH 2 13 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1881
9. AGE (In years last birthday) 78 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Publisher	
11. BIRTHPLACE (State or foreign country) Cherry Creek N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Reed Huntley		14. MOTHER'S MAIDEN NAME Fidelia Frost	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrytle Huntley		Address Ashton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon with metastases DUE TO (b) 15-3 DUE TO (c) 4 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 56 to 2/13 1960 , that I last saw the deceased alive on 2/13 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring Md.			
ACTUAL SIGNATURE C. H. L. Ligon		DATE SIGNED 2/13/60	
PHYSICIAN'S NAME (Type) C. H. L. Ligon		M.D. Sandy Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped	22b. DATE THEREOF 2/15/60	22c. NAME OF CEMETERY OR CREMATORY Forrest Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Buffalo, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE JOSEPH GAWLER'S SONS, INC.		24a. REC'D BY REGISTRAR FEB 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

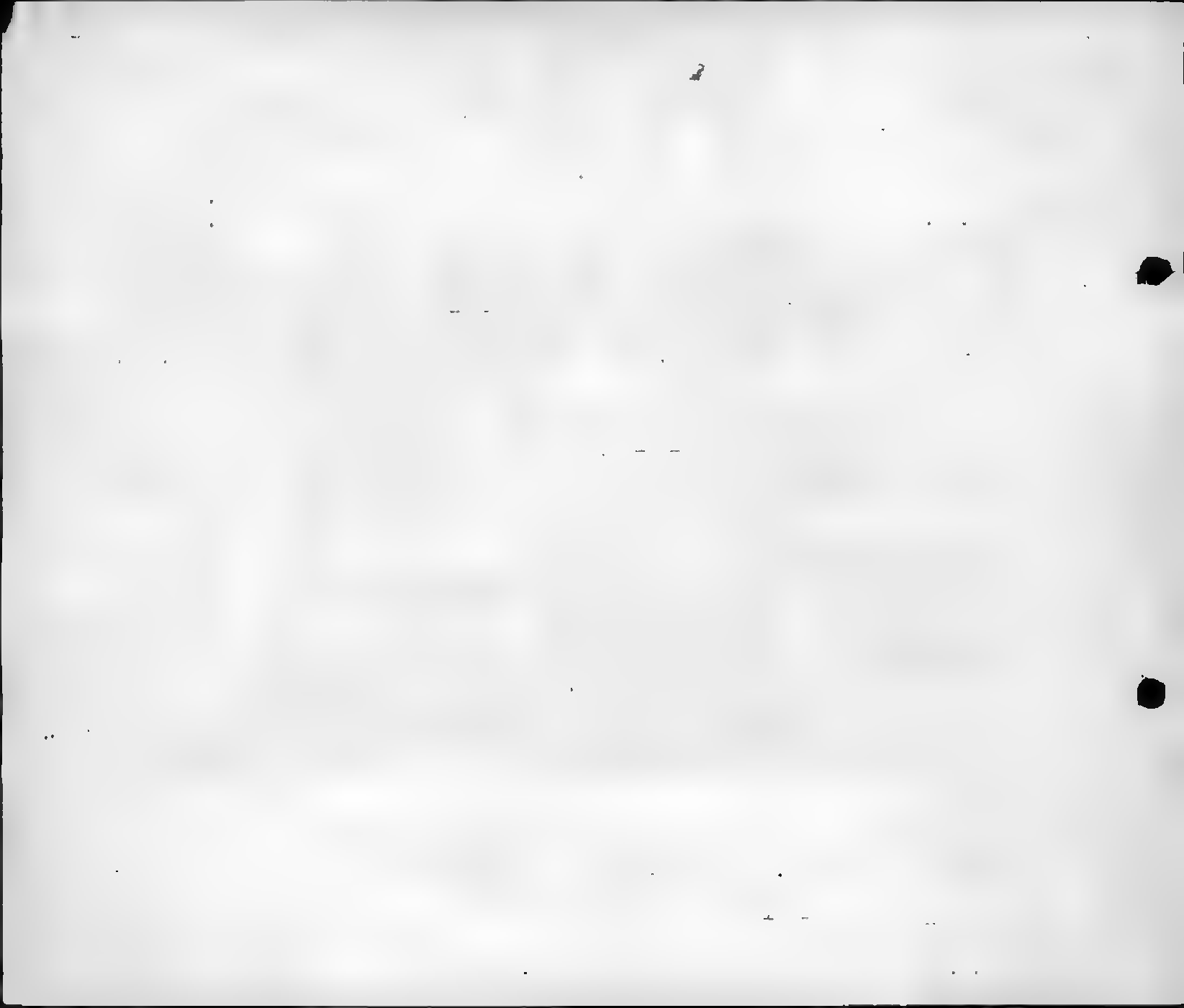
02174

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Marion</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion</u>		
c. LENGTH OF STAY IN 1b <u>13 hrs.</u>			d. STREET ADDRESS <u>1815 Miller Ave.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>			e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lionel Vernon HUSTON</u>			4. DATE OF DEATH Month Day Year <u>February 18 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-34</u>		9. AGE (In years last birthday) <u>25</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John David Huston</u>			14. MOTHER'S MAIDEN NAME <u>Helen Mae Adams</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1952 to DOD</u>		16. SOCIAL SECURITY NO <u>312-32-6800</u>	17. INFORMANT <u>Hospital Records</u> Address _____		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull</u> (c) <u>Multiple injuries extreme</u> stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in pvt. auto which skidded off road and struck tree</u>			
20c. TIME OF INJURY Month, Day, Year <u>1:40 a.m. 2/17 1960</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 222 near</u>	20f. (City or town) <u>Bainbridge Md</u>	(County) <u>Lancaster</u>	(State) <u>Pa.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-18-60</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial-Shipment</u>	22b. DATE THEREOF <u>2-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>	22d. LOCATION (City, town, or county) <u>Marion Indiana</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers by Lia</u>		ADDRESS <u>WashDC</u>		24a. REC'D BY REGISTRAR <u>FLB 2 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>W. S. Hume</u>
W.W. Chambers Funeral Home, 1400 Chapin St. NW,					



CERTIFICATE OF DEATH

Reg. Dist. No.

02175

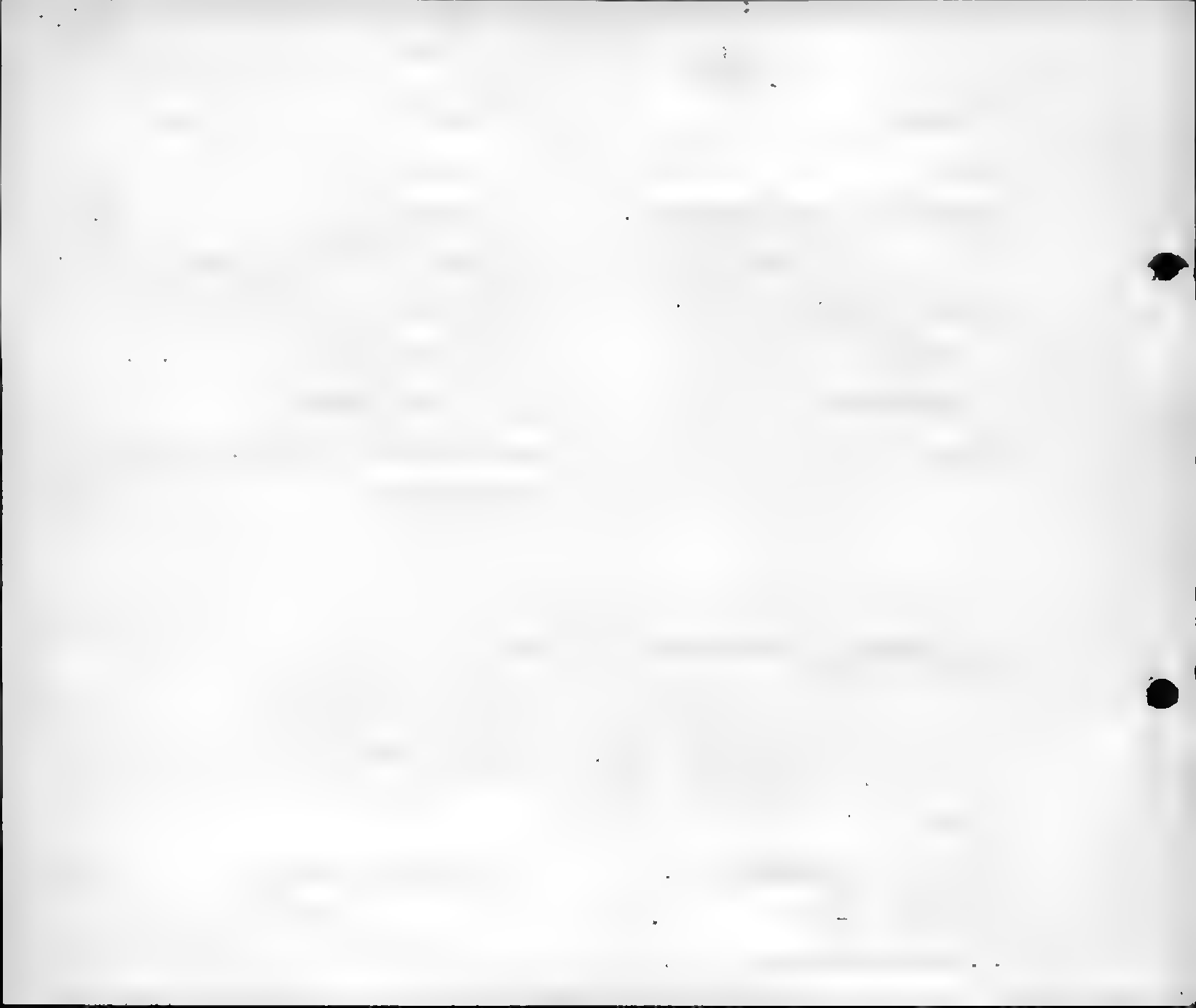
2228

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville		d. STREET ADDRESS Hall Shop Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Iager		4. DATE OF DEATH Month Day Year February 10 19 60		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/12/1880		9. AGE (In years last birthday) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Iglehart		14. MOTHER'S MAIDEN NAME Mary Harding		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT Hospital Records,		Address Olney, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial failure — 10 days		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1 , 19 60 , to Feb. 10 , 19 60 , that I last saw the deceased alive on Feb. 9 , 19 60 , and that death occurred at 7 AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED 2/10/60													
ACTUAL SIGNATURE Charles S. Whitaker		M.D. _____		PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.		_____ Clarksville, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-60		22c. NAME OF CEMETERY OR CREMATORY St. Pauls	
22d. LOCATION (City, town, or county) (State) Fulton, Md		23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbotham, Ellicott City, Md		ADDRESS _____		24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



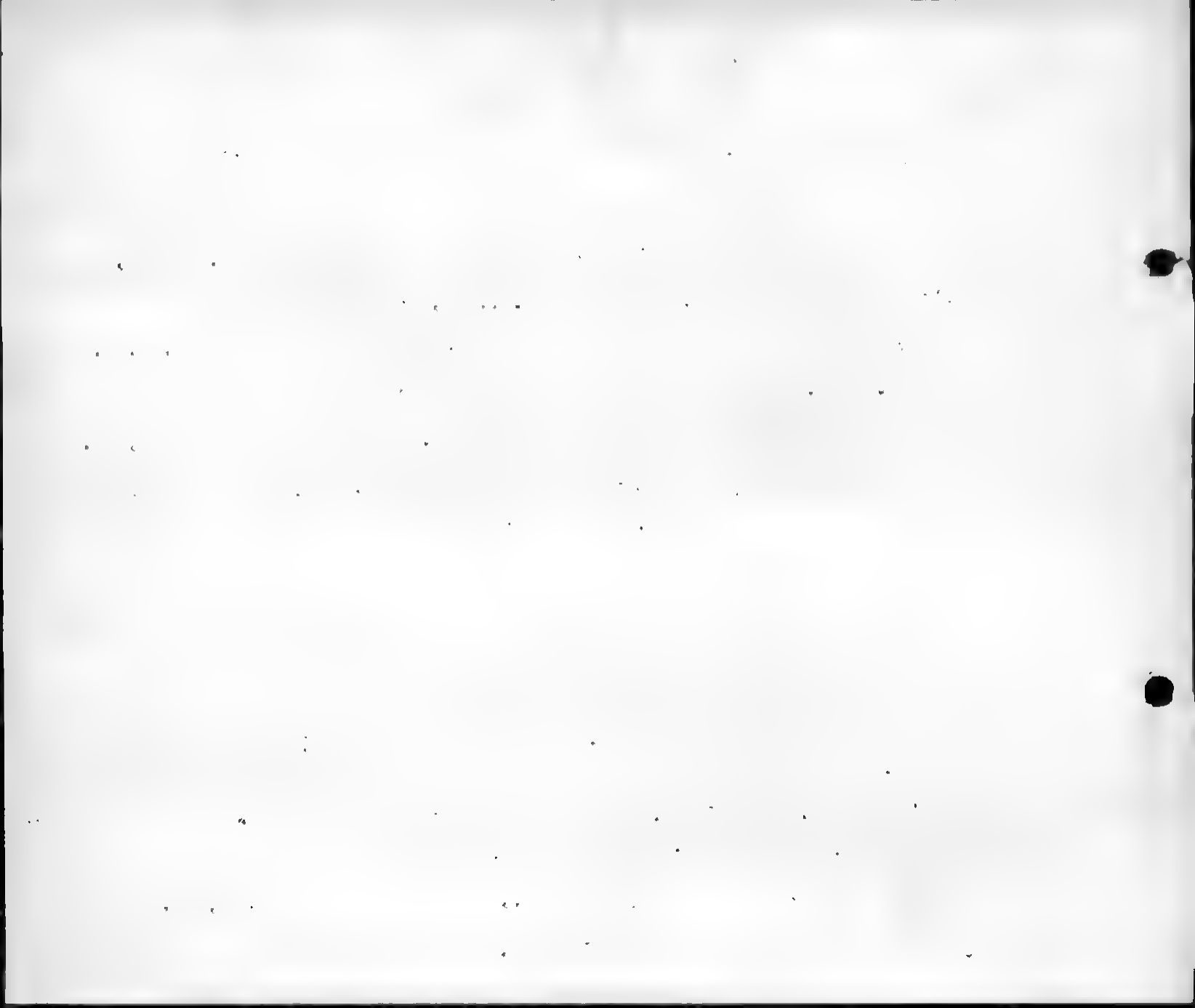
2229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (Rural)				c. LENGTH OF STAY IN 1b X Gaithersburg (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle CLINTON Last IMES				4. DATE OF DEATH Month Feb. Day 21 Year 19 60			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1899	9. AGE (In years last birthday) yrs. 60	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Imes				14. MOTHER'S MAIDEN NAME Bertie Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Katherine R. Dyson		Address Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED DUODENAL ULCER 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duodenal Ulcer DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 1 year						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3:30 , 19 60 , to FEB. 21 , 19 60 , that I last saw the deceased alive on FEB. 20 , 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Frank				ADDRESS (Street, city or town, state) 544 W MONTGOMERY AVE. ROCKVILLE, MD.			
PHYSICIAN'S NAME (Type) WILLIAM FRANK, M.D.				DATE SIGNED 2/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/60		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove..		22d. LOCATION (City, town, or county) (State) Poplar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE FEB 25 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2230 CERTIFICATE OF DEATH

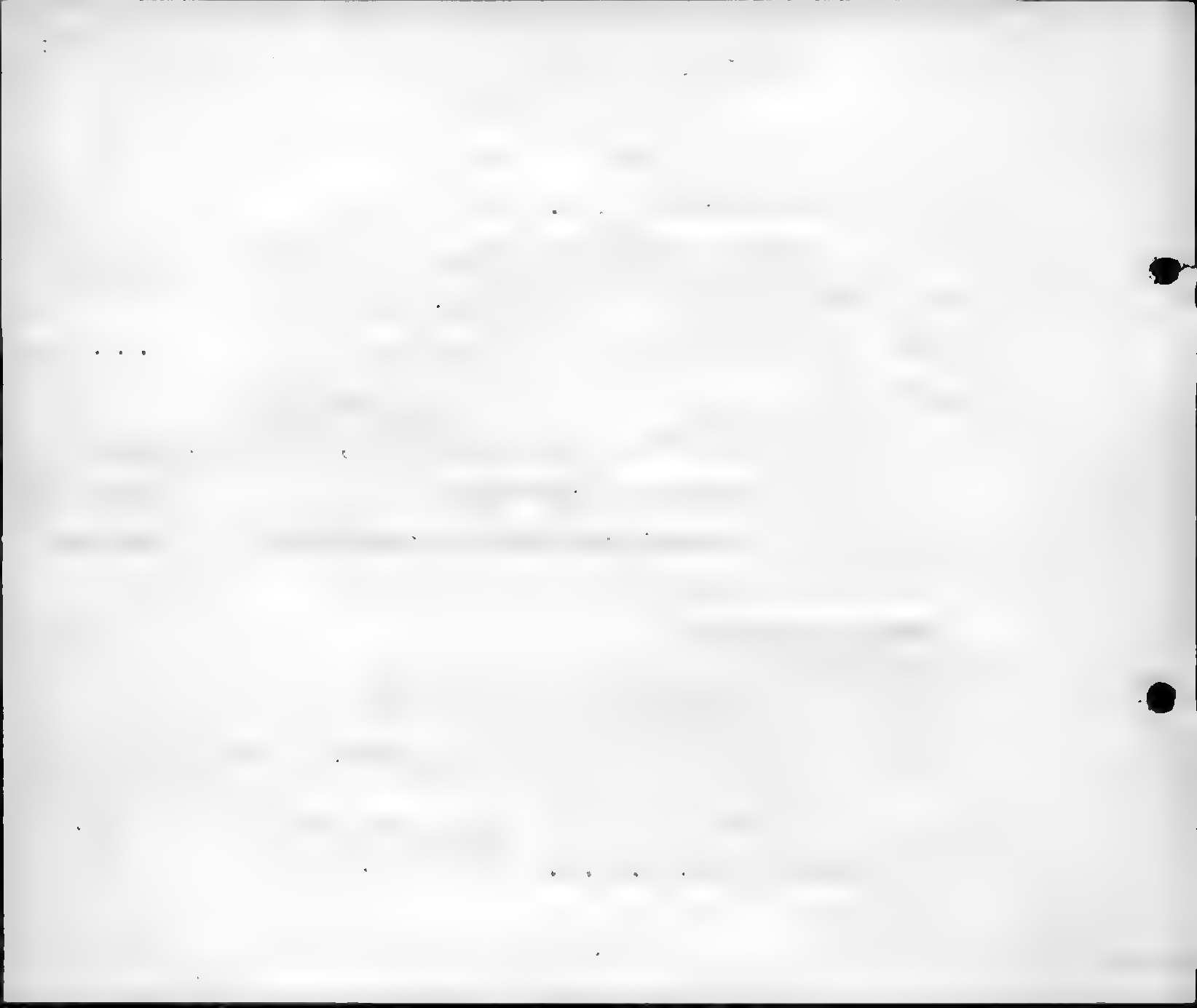
Reg. Dist. No.

02177

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE New York b. COUNTY Brooklyn c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn d. STREET ADDRESS 1611 49th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Phyllis Middle (None) Last Iozzia		4. DATE OF DEATH Month February Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1949
9. AGE (In years last birthday) 10		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Iozzia		14. MOTHER'S MAIDEN NAME Louise Raffaniello	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 195.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma of the adrenal cortex DUE TO (c) Hepatic decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic decompensation			INTERVAL BETWEEN ONSET AND DEATH hours 1 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 7, 1960 to February 8, 1960 that I last saw the deceased alive on February 8, 1960 and that death occurred at 3:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Leeman Lewis, Jr.</i>		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) JOHN LEEMAN LEWIS, JR., M. D.		DATE SIGNED 2/8/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY U. S. NATIONAL		22d. LOCATION (City, town, or county) (State) LONG ISLAND N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ronald Funeral Home</i>		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
ADDRESS 816 N. J. F. N. E.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>Rt. #2</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>
9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Albert Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>INFORMANT</u> <u>Florance Johnson Rt. #2, Rockville, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>464x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchio Phlebothrombosis</u> (c) <u>Bronchopneumonia & abscesses</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2-3 weeks</u> <u>4-6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/21/60</u> , 19 <u> </u> , to <u>2/21/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2/20/60</u> , 19 <u> </u> , and that death occurred at <u>1:15</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates, M.D.</u>		ADDRESS (Street, city or town, state) <u>2/22/60</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Yates, M.D.</u>		<u>Olney, Maryland</u>	
22a. BURIAL, CREMATATION OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant.</u>	22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swadlow</u>		ADDRESS <u>Rockville, Md.</u>	24a. REC'D BY REGISTRAR <u>FEB 25 '60</u> DATE
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Florance</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director.

may be retained by the hosp 101 or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled in by the funeral director. Then please remove carbon papers. After death.

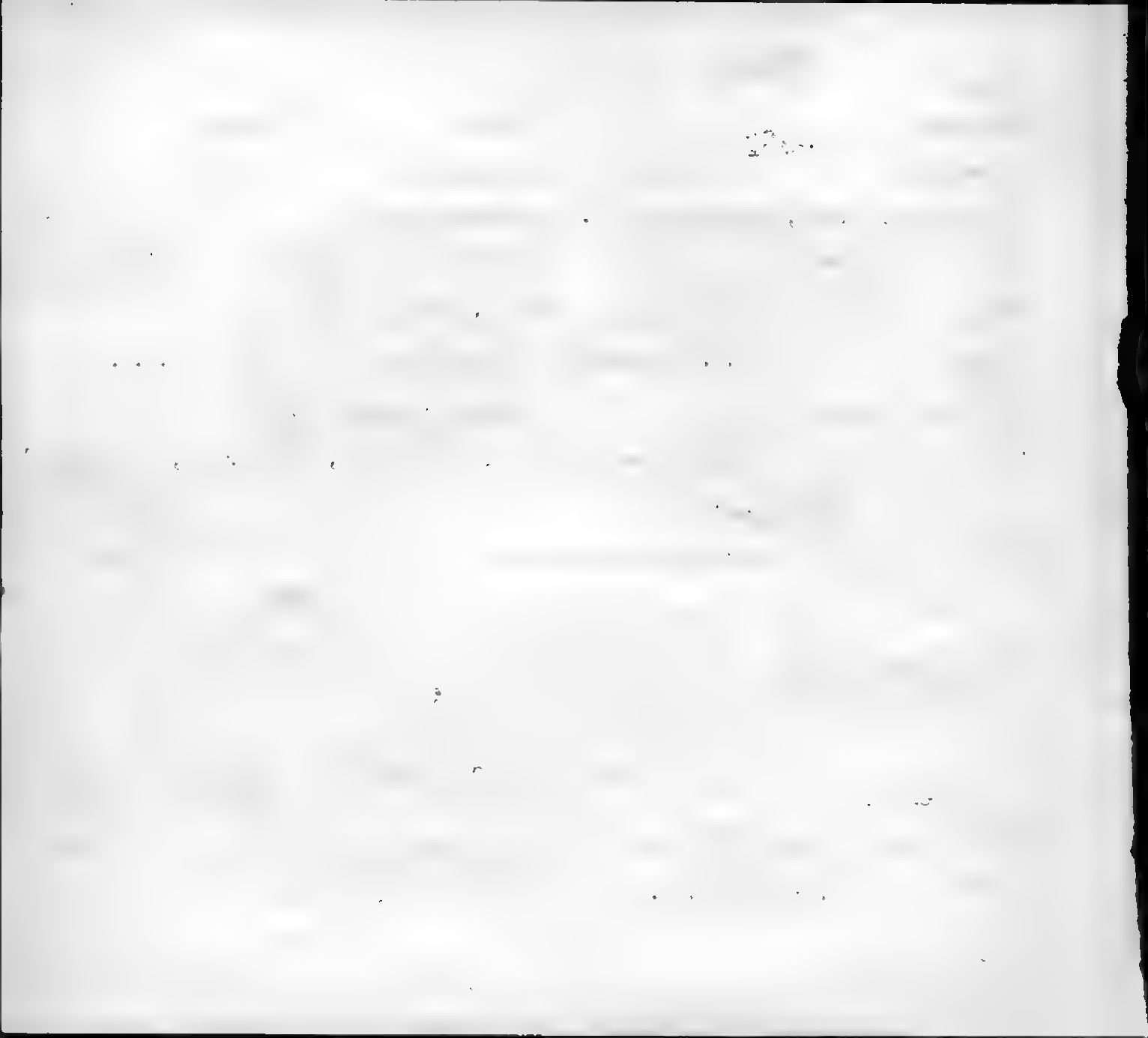
3580

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 50 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 508 Faber Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Arthur Last Johnstone				4. DATE OF DEATH Month February Day 29 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1907		9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Otto Johnstone				14. MOTHER'S MAIDEN NAME Amanda Swenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Reticulum cell sarcoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Days 1 year							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1960 , to February 29, 1960 , that I last saw the deceased alive on February 29, 1960 , and that death occurred at 3:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 3/1/60							
ACTUAL SIGNATURE Harold J. Fallon M.D.		PHYSICIAN'S NAME (Type) HAROLD J. FALLON, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/60		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Blair R. Thomas Arlington Funeral Home		ADDRESS 3901 North Fairfax Dr.		24a. REC'D BY REGISTRAR MAR 3 '60		24b. REGISTRAR'S SIGNATURE Clifford S. Kline	

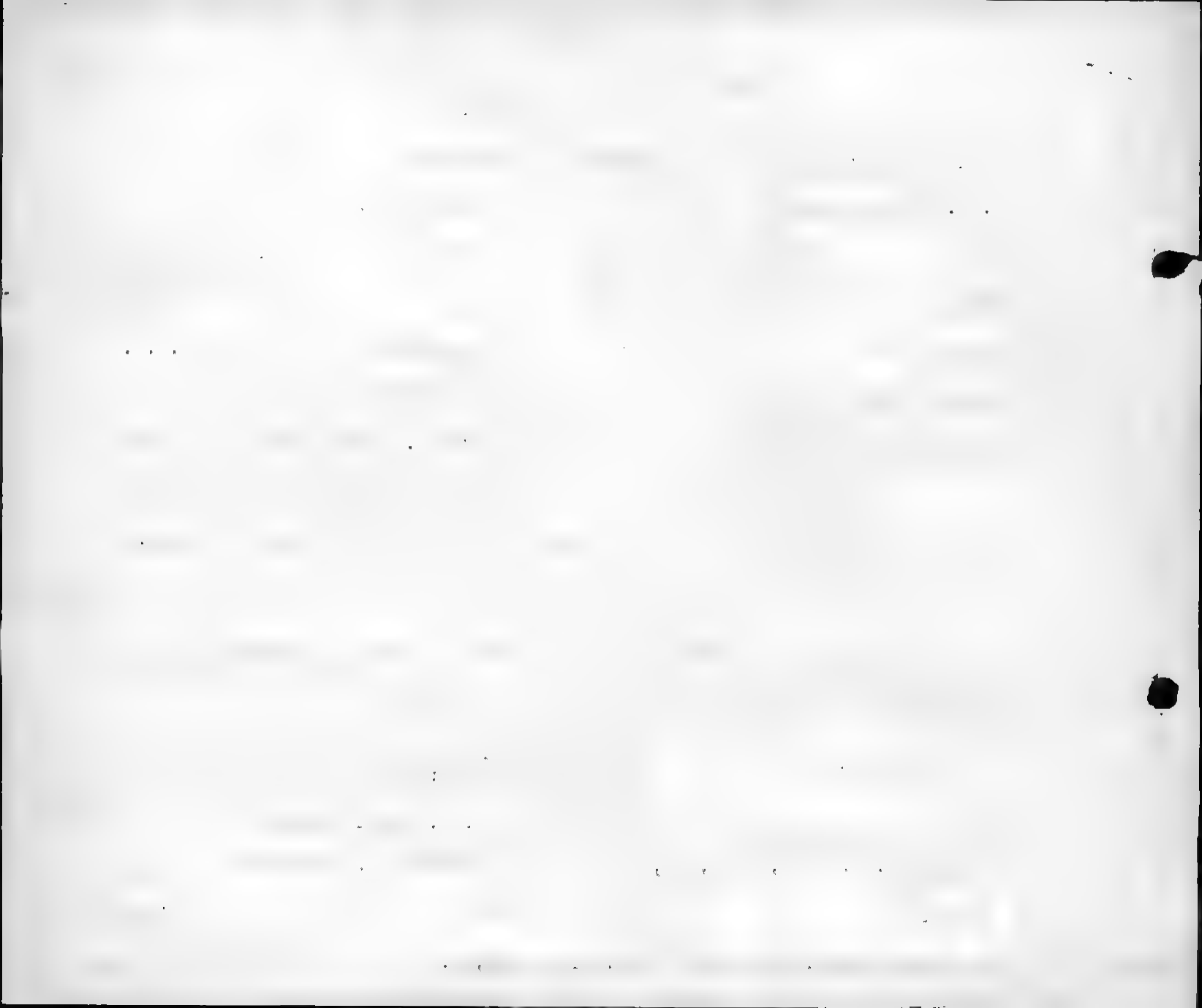
Arlington, Va.



CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		2232 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 87 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 215 Thor Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jo-An Middle Ellen Last JONES		4. DATE OF DEATH Month February Day 19 Year 1960			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-32	9. AGE (In years lost birthday) 27 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ralph JONES		14. MOTHER'S MAIDEN NAME Ellen ERNST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1951 to 1953		INFORMANT (H) Laverne L. Jones, same as #2 above	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis and infarction 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) anterior communicating artery (cerebral) aneurysm DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from November 24, 1959 to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred at 10:40 A.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) U. S. Naval Hospital		DATE SIGNED 2-20-60	
ACTUAL SIGNATURE M. W. Wood MD		PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington		22e. (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd. Arlington, Va		24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2233 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, give STATE) North Carolina b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Lejeune	
f. STREET ADDRESS MEMO 1221, Air Facility		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Karen Middle Lee Last JONES		4. DATE OF DEATH Month February Day 16 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-59
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR 2 Months 3 Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. KIND OF BUSINESS OR INDUSTRY - - - - -	
13. BIRTHPLACE (State or foreign country) North Carolina		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Thomas Semmes JONES		16. MOTHER'S MAIDEN NAME Irene KNIGHTON	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. None INFORMANT Hospital Records Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) endocardial fibroelastosis (c) congenital mitral and aortic stenosis		INTERVAL BETWEEN ONSET AND DEATH 1.5 hours 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) aspiration pneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 3, 1960 , to February 16, 1960 , that I last saw the deceased alive on February 16, 1960 , and that death occurred at 1:51 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Mazur M.D.		ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2-16 59	
PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Shipment		22b. DATE THEREOF 2-18-60	
22c. NAME OF CEMETERY OR CREMATORY Memphis Tennessee		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES CO., 2901 14th St., NW, Washington DC ADDRESS		24a. REC'D BY REGISTRAR FEB 18 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2142

CERTIFICATE OF DEATH

02182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eventide - 700 Hudson Av.</u>		d. STREET ADDRESS <u>3109 Beech St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET Elizabeth Jones</u>		4. DATE OF DEATH <u>Feb 1, 1960</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Monroe Eyles</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Stamp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>331X</u>	
17. INFORMANT <u>Gladys Wakefield, 700 Hudson Park</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (weak)</u> DUE TO (b) <u>Cerebral Arterio-sclerosis</u> DUE TO (c) <u>Arterial Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis of Scurley</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 20, 1960</u> to <u>Feb 1, 1960</u> , that I last saw the deceased alive on <u>Jan 31, 1960</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave. Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		DATE SIGNED <u>Feb 1, 1960</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brookville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>Ellsworth Armacost-4600 Liberty Hgts. Ave.</u>		24a. REC'D BY REGISTRAR <u>Feb 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Kane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2234

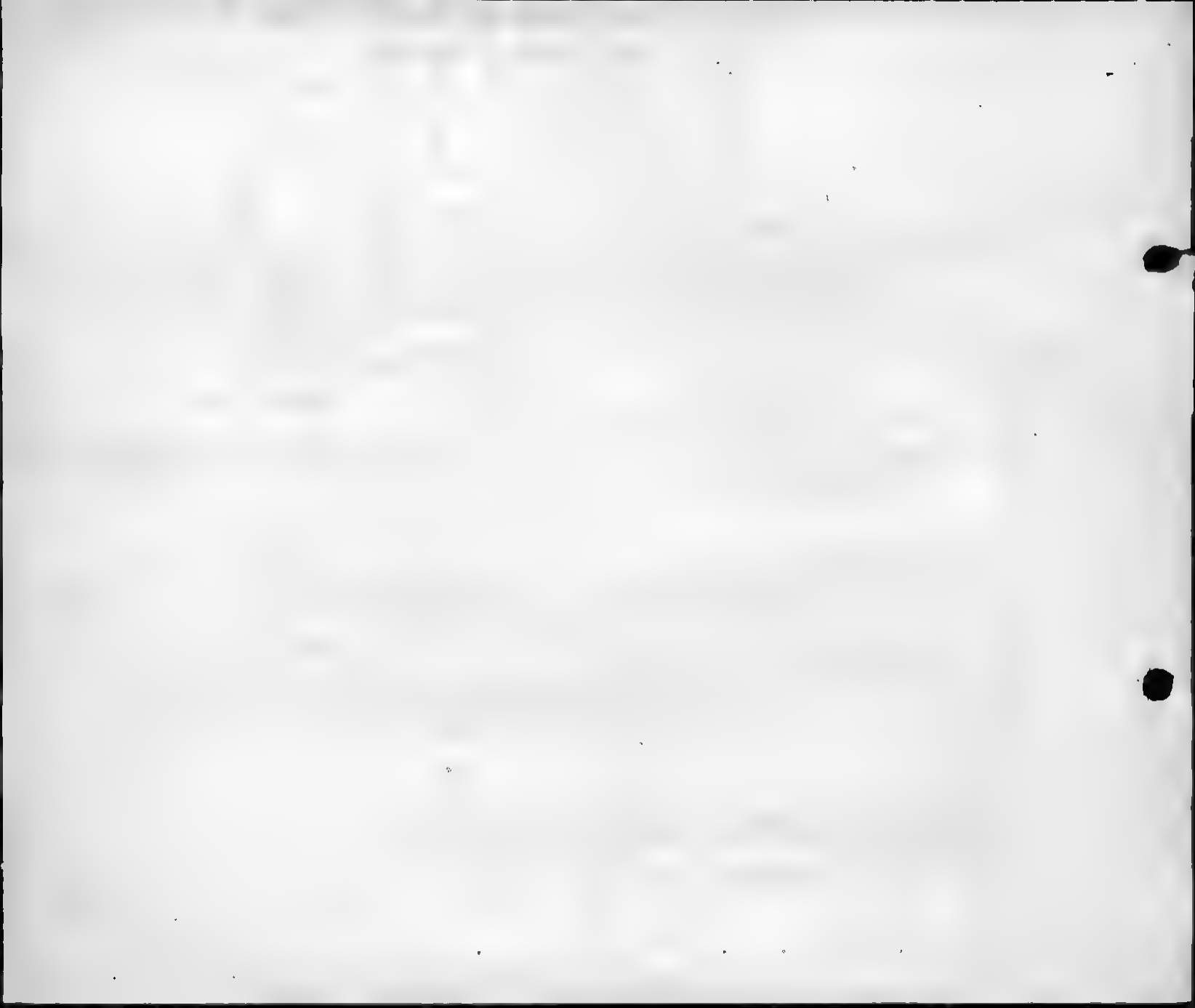
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookside Grove Found. INC</u>				d. STREET ADDRESS <u>1920 S. St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Riva</u> Middle <u>EL</u> Last <u>KELLY</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 1875</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min <u>84</u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Davis L. Gibson</u>				14. MOTHER'S MAIDEN NAME <u>DUNBAR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Carl Kelly</u> Address <u>3201 Jant Rd Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Influenza</u> DUE TO <u>4.1X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Fract. left Femur (neck)</u> DUE TO <u>Sen. art. Sclerosis + Scurvy</u> (c) <u>109.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>109.1</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2 Jan</u> , 19 <u>55</u> to <u>3 Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2 Feb</u> , 19 <u>60</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Bosley Zeigler</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesley, Md</u> DATE SIGNED <u>2/26/60</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZEIGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

02184

2235

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 4505 SIGSBEE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN EDWARD KEMP				4. DATE OF DEATH Month Day Year FEBRUARY 2 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/28/03	
9. AGE (In years last birthday) 56		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY TRANSIT CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME EDWARD W. KEMP				14. MOTHER'S MAIDEN NAME MARGARET LOUISE DAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT HOSPITAL RECORDS				Address OLNEY, MO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism (Massive) 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Prostatic Veins Thrombosis DUE TO (c) Route pulmonary edema INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from years 1955 to Feb 2 1960 that I last saw the deceased alive on 2/2 1960 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE L. I. Leal M.D.							
PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.				GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL DATE THEREOF FEB 6 1960				22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Barber ADDRESS Laytonsville, Md				24a. REC'D BY REGISTRAR FEB 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02185

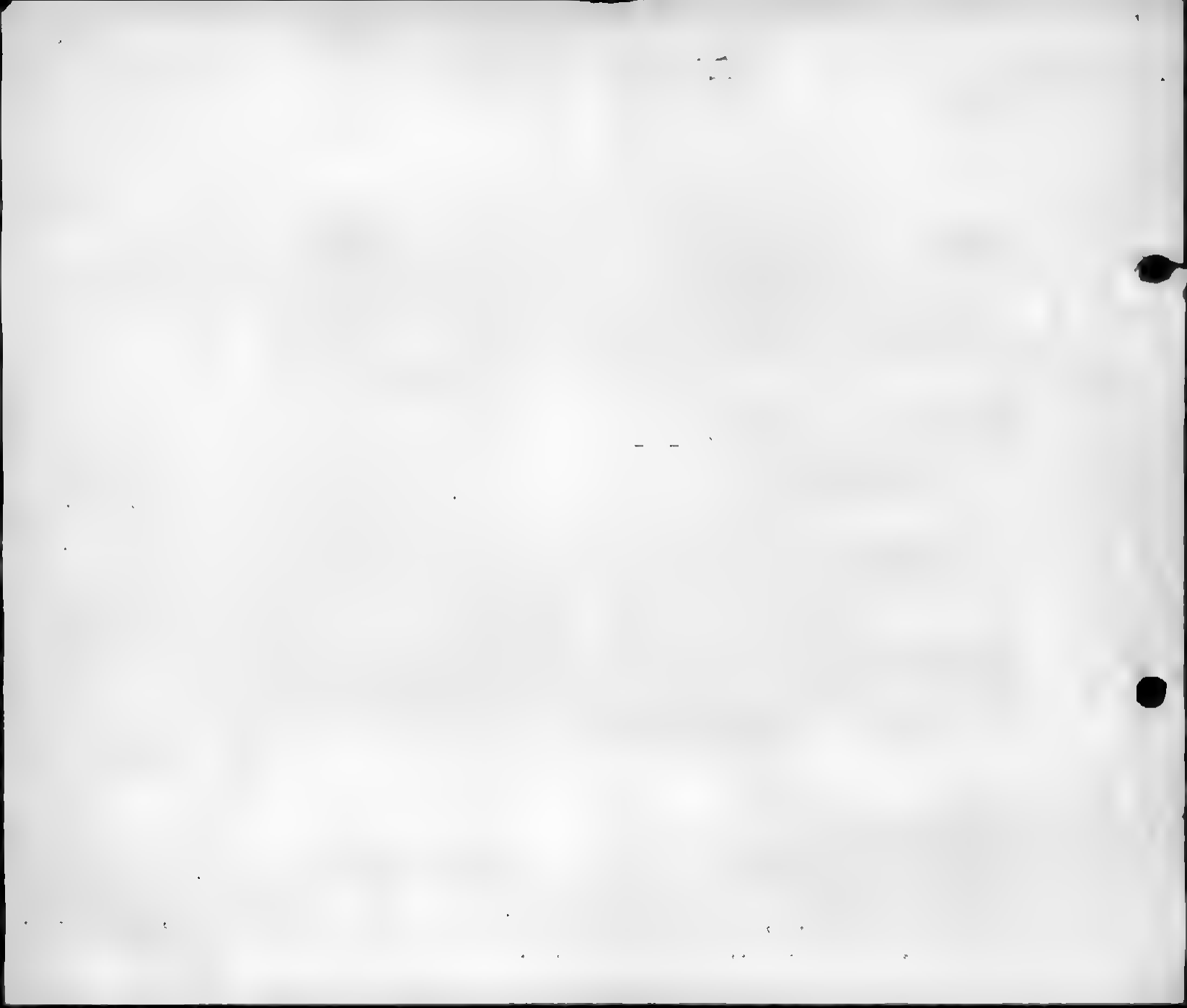
Reg. Dist. No.

2143

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hosp</u> e. STREET ADDRESS <u>406 Dale Drive</u> f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
3. NAME OF DECEASED (Type or print) <u>Nora Olive Kemp</u> First Middle Last 4. DATE OF DEATH <u>2 - 1 - 1960</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-14-74</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>85</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Produce</u> 11. BIRTHPLACE (State or foreign country) <u>Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Warren Watson</u> 14. MOTHER'S MAIDEN NAME <u>Martha Taylor</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>257-50-2481</u> 17. INFORMANT <u>Hospital Records</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>900.0 Congestive heart failure</u> DUE TO (b) <u>Primary pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Fracture of ribs (left)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 days</u> <u>27 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair steps at home</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>1 - 4 1960</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb 1 1960</u> DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>FEB. 4, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>MIDWAY CHURCH CEMETERY</u> 22d. LOCATION (City, town, or county) <u>NEAR LOST MOUNTAIN, MARIETTA, GA.</u> (State)				23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Ziska</u> 24a. REC'D BY REGISTRAR <u>Feb 3 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2144

CERTIFICATE OF DEATH

Reg. Dist. No.

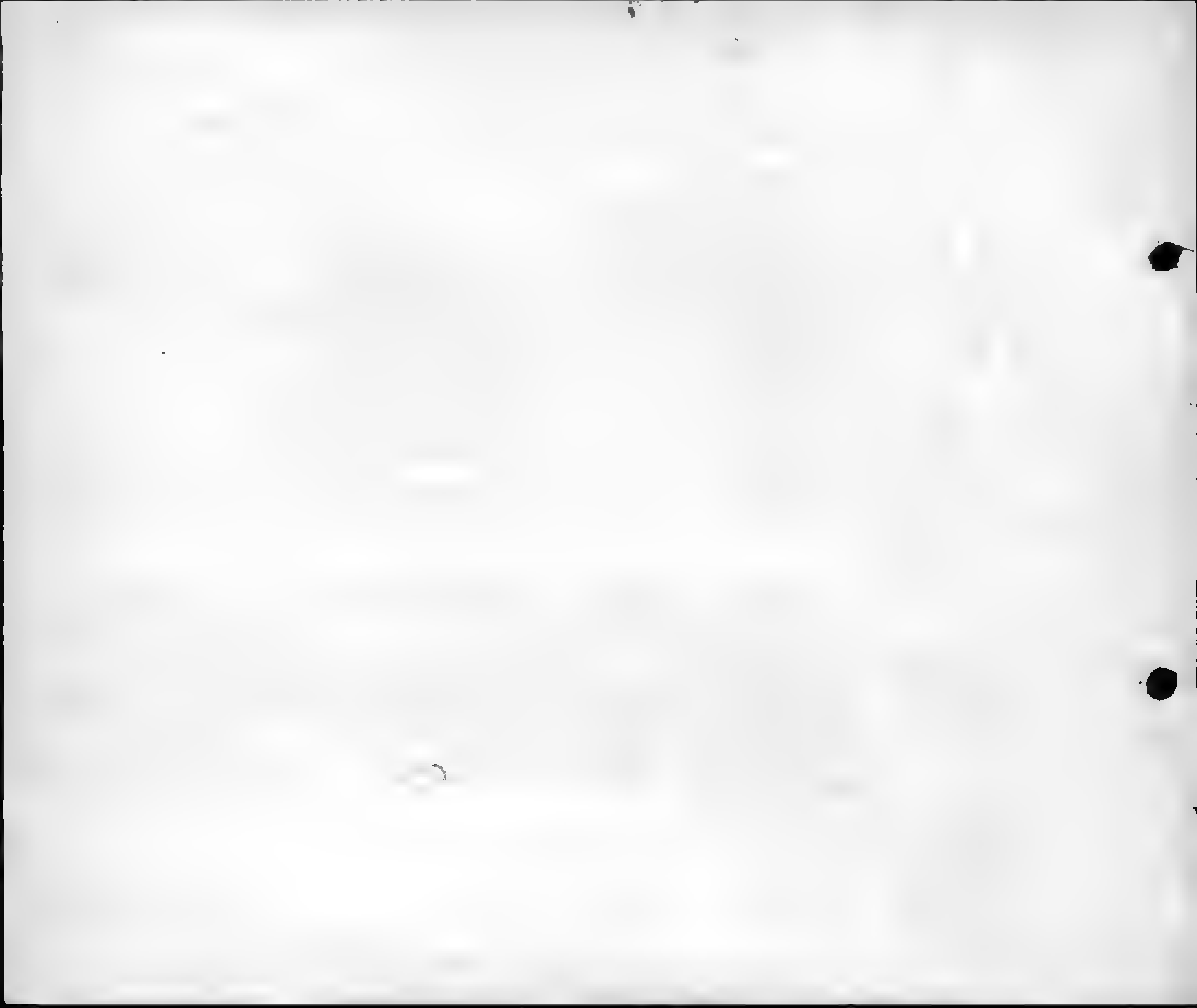
02186

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hospital</u>		d. STREET ADDRESS <u>7503 Flower Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Daniel</u> Last <u>Kimble</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James D. Kimble</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO (b) <u>Intestinal Stenosis</u> DUE TO (c) <u>Intestinal Obstruction + toxicity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>one day</u> b. <u>one week</u> c. <u>one month</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>Feb 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>60</u> , and that death occurred at <u>10:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A Hare</u>		ADDRESS (Street, city or town, state) <u>Takoma Park Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A Hare, MD</u>		DATE SIGNED <u>2/3/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 6, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>New York State</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Canal St NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2145

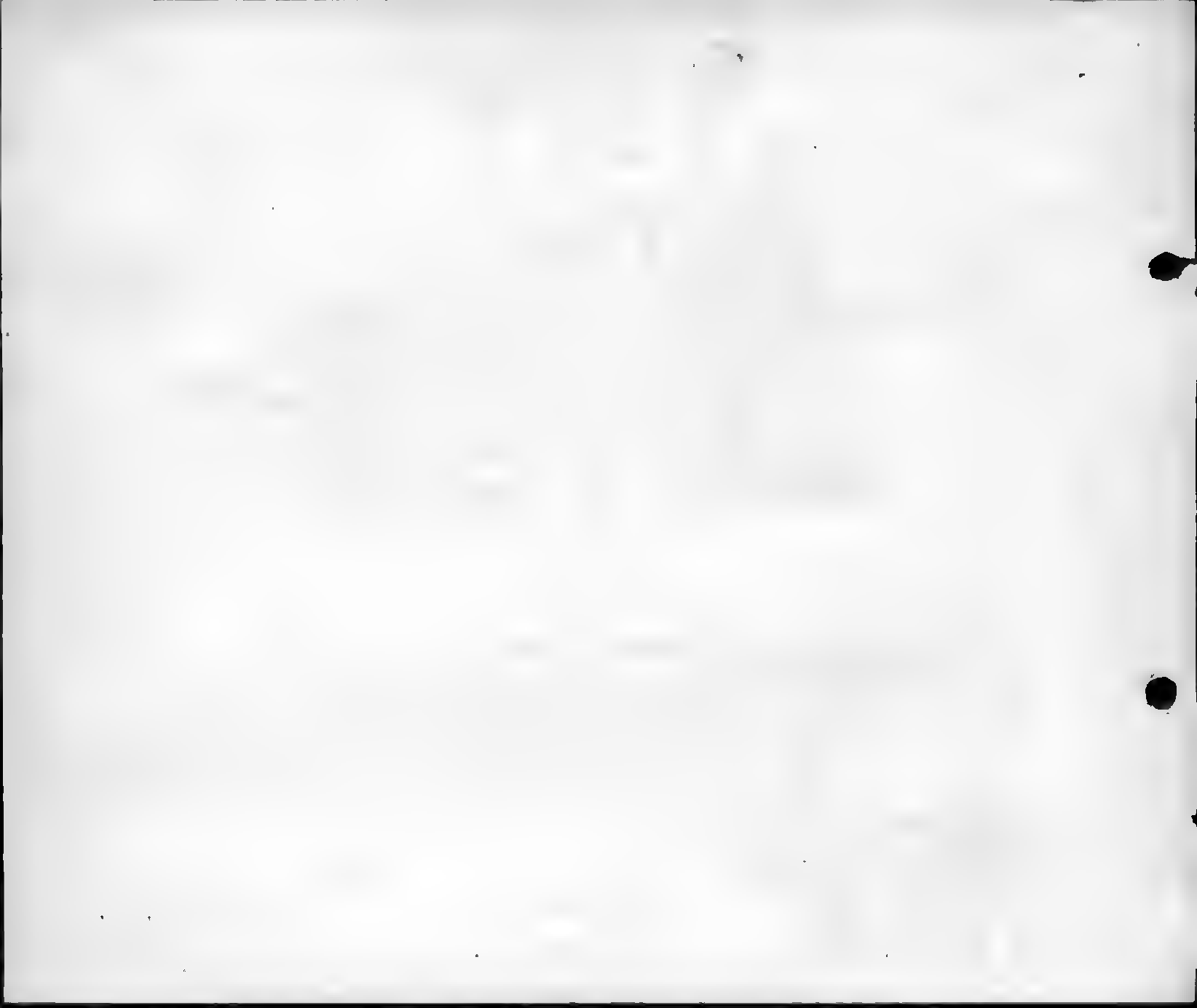
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San E Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hogansville</u>	
f. STREET ADDRESS <u>1903 Erie St Apt 102</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cladys</u> Middle <u>Bailey</u> Last <u>King</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-93</u>
9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Emily E. GREGORIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>circulatory collapse.</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral hemorrhage.</u> DUE TO <u> </u> (c) <u>cerebral arteriosclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u> <u>8 days.</u> <u>indefinite.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-30-1960</u> to <u>2-7-1960</u> that I last saw the deceased alive on <u>2-7-1960</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>		ADDRESS (Street, city or town, state) <u>929 Plunking Drive, Silver Spring, Md.</u>	
DATE SIGNED <u>2-7-60</u>			
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City town or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 9 '60</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

Reg. Dist. No.

02189

2235

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney LaPlata Indian Head	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Nursing Home		d. STREET ADDRESS 08X-2	
3. NAME OF DECEASED (Type or print) First Joseph Middle William Last Kronk		4. DATE OF DEATH Month 2 Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1873
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR: Months 15 Days 15 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis M. Kronk		14. MOTHER'S MAIDEN NAME Elizabeth Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO Spanish-American War none	
17. INFORMANT Carlin M. Cronk, 10 First St., Indianhead, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus 46X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/13 , 1955, to 2/18 , 1960 that I last saw the deceased alive on 2/18 , 1960, and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 2/18/60	
PHYSICIAN'S NAME (Type) H. D. BONIFANT, M.D.		Sandy Spring, Maryland 2, 18, 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/1960	
22c. NAME OF CEMETERY OR CREMATORY Park Hill Cemetery		22d. LOCATION (City, town, or county) (State) Marbury Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Archart Funeral Home, Inc. LaPlata, Md.		24a. REC'D BY REGISTRAR FEB 23 '60 DATE	
24b. REGISTRAR'S SIGNATURE [Signature]			

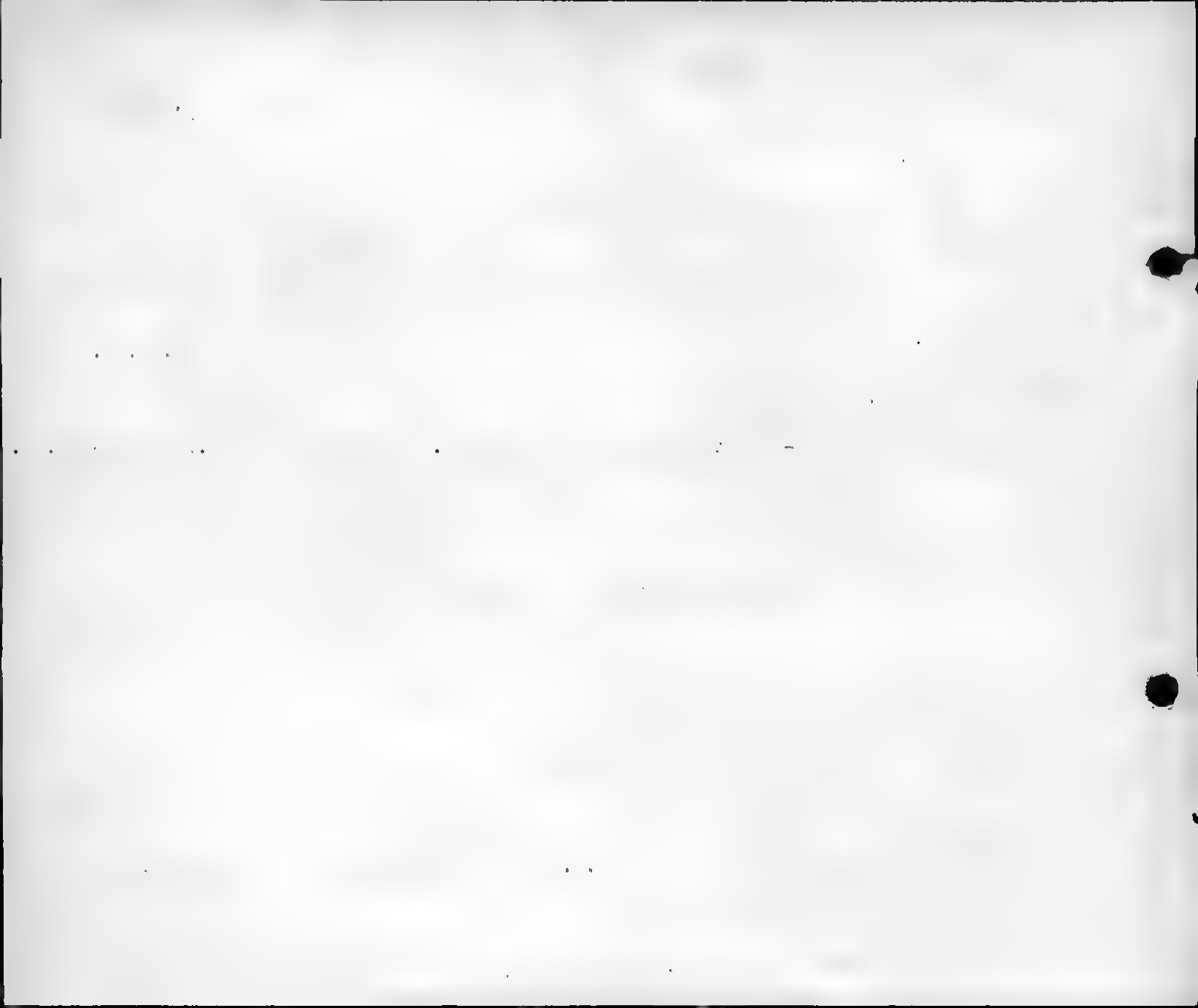
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain on the premises. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2237 CERTIFICATE OF DEATH

Reg. Dist. No.

02190

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resnow Lane</u>		d. STREET ADDRESS <u>3815 Calvert St.</u>	
3. NAME OF DECEASED (Type or print) <u>RACHEL L LAMBERT</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert John</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>LEROY R. SWEETMAN</u>		Address <u>3815 Calvert NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>423.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Senile Sclerotic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 19, 1945</u> to <u>Feb. 20, 1960</u> , that I last saw the deceased alive on <u>Feb. 19, 1960</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>J. E. Mannon</u>		ADDRESS (Street, city or town, state) <u>3141-38th Ave NW</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. CRANNON</u>		DATE SIGNED <u>Feb 23 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-22-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Ebel</u>		24a. REC'D BY REGISTRAR <u>2224-11th Ave NW, D.C.</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>FEB 23 '60</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

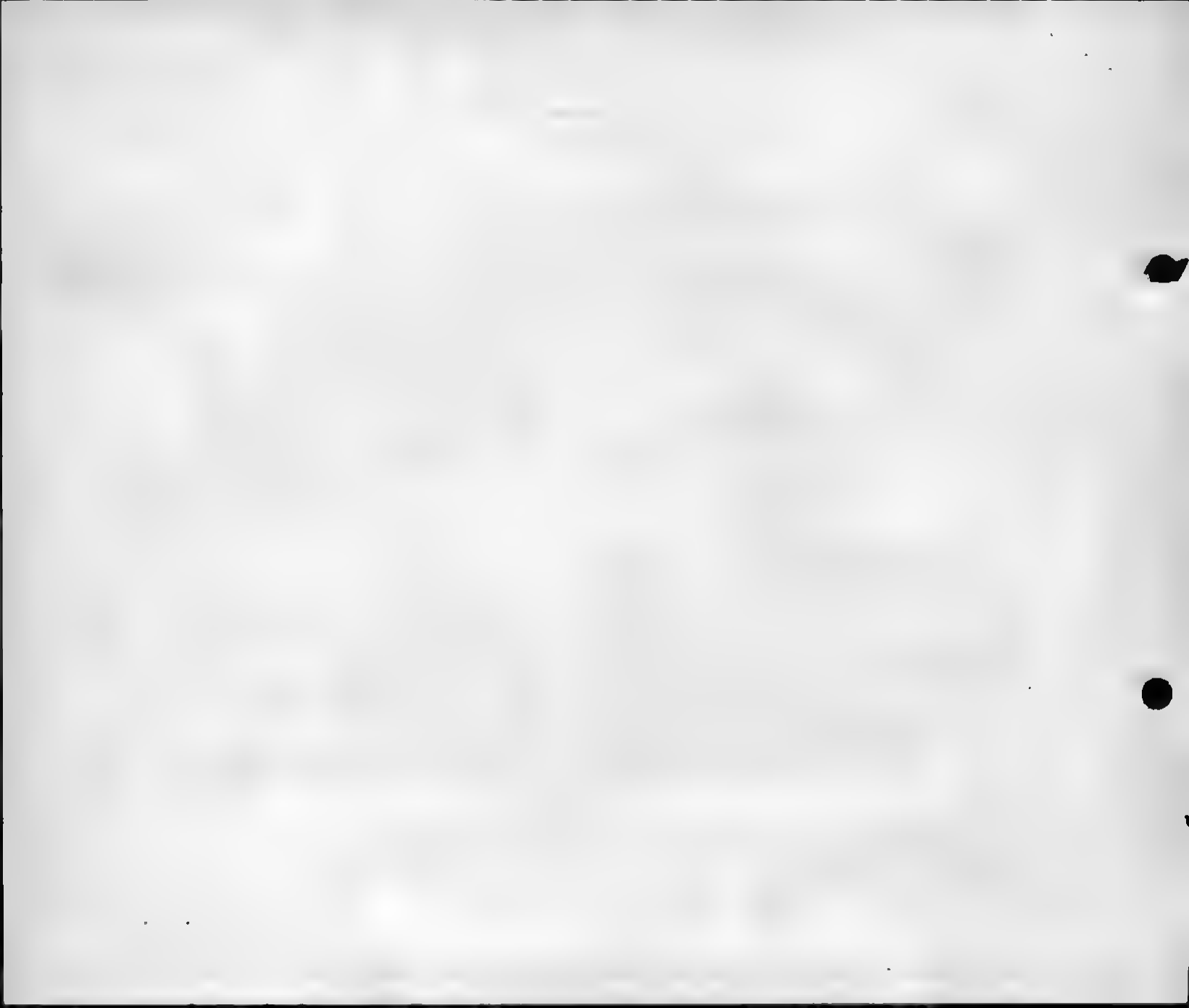
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SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02191

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase Md.</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Md.</u>		d. STREET ADDRESS <u>7105 46th St., Cherry Chase Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Mary</u> Last <u>Lappin</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1960</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1866</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John McCristel</u>				14. MOTHER'S MAIDEN NAME <u>Frances M. Byrne</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Katherine Hutchinson, Daughter</u>		Address <u>7105 46th St., Cherry Chase Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u>year</u>										2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-8-60			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Farnes</u>	



2238

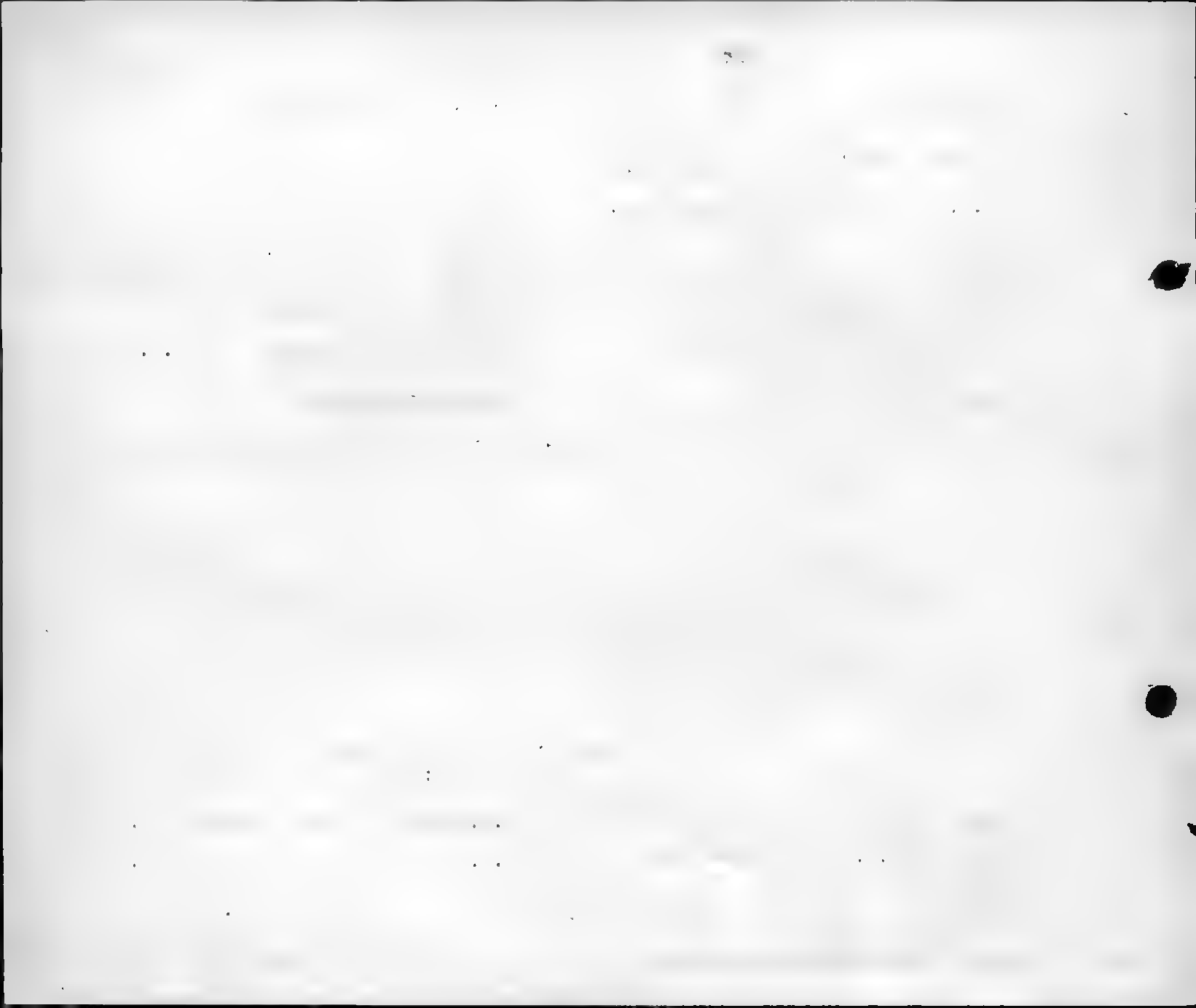
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived (If first burial: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN Tb 14 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last LEDoux				4. DATE OF DEATH Month February Day 23 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-64	
9. AGE (In years last birthday) yrs 95		IF UNDER 1 YEAR Months 2 Days 12 Hours 0 Min.		IF UNDER 24 HRS Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John HOWE				14. MOTHER'S MAIDEN NAME Frances ROBERTSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no			
17. INFORMANT (Son) Lenderville LEDoux				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fracture/simple right hip DUE TO (c) General old age and debility INTERVAL BETWEEN ONSET AND DEATH 2 days 12 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9 February, 1960 to 23 February, 1960 , that I last saw the deceased alive on 23 February, 1960 , and that death occurred at 12:12 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 2-23-60 ACTUAL SIGNATURE K.F. SPENCE M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) K.F. SPENCE LT MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee's				ADDRESS 4th & Massachusetts Ave NW WDC		24a. REC'D BY REGISTRAR FEB 29 '60	
24b. REGISTRAR'S SIGNATURE William S. Haines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

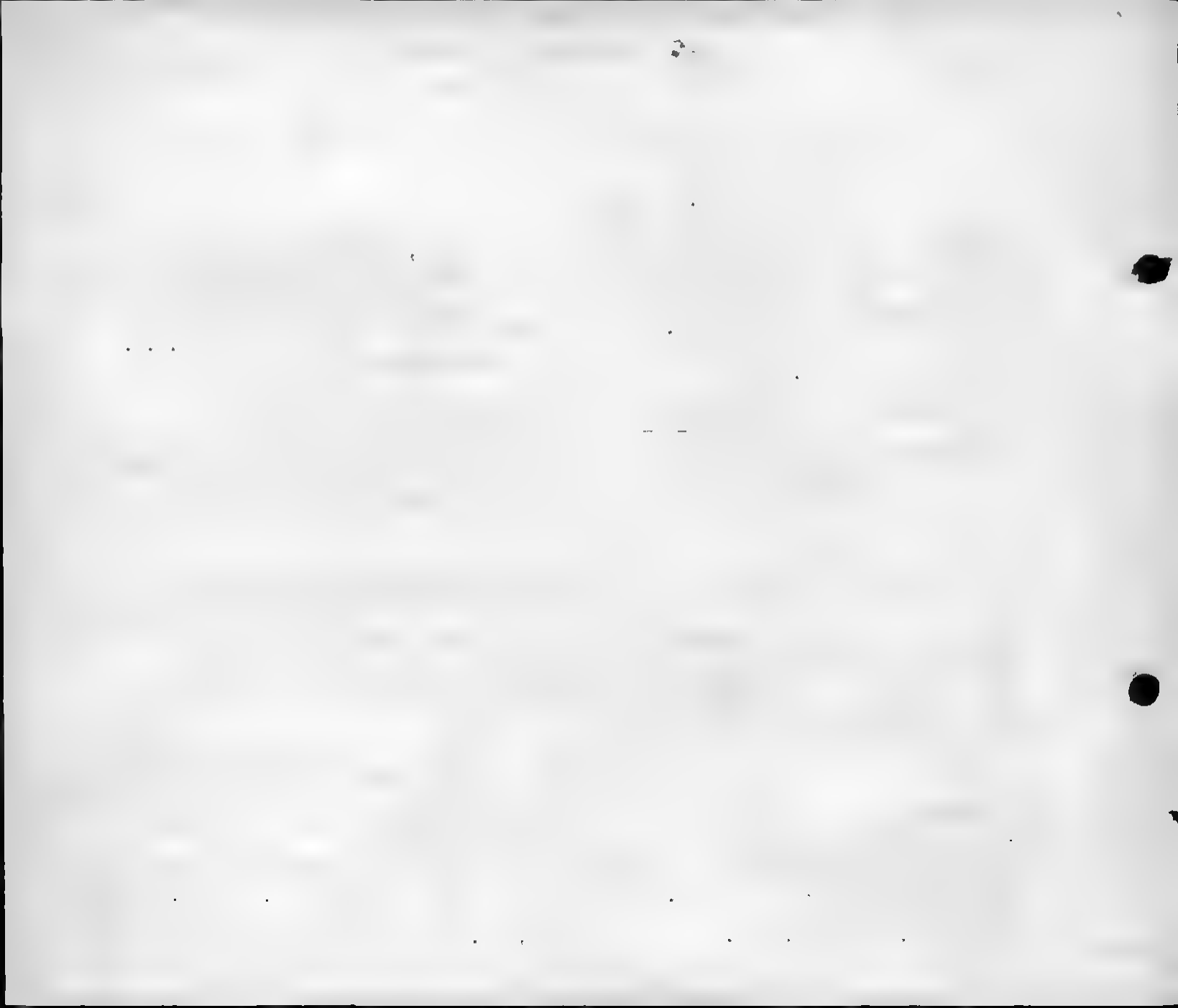
2147 CERTIFICATE OF DEATH

Reg. Dist. No.

02194

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN It <u>25 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
		d STREET ADDRESS <u>718 Pershing Drive</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Merle</u> Last <u>Lerch, SR</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-93</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Print Leader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Printing Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD P. Lerch</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>213-38-3503</u>	
		17. INFORMANT <u>W.S. Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>42.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>57</u> , to <u>Feb 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>60</u> , and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8248 Georgia ave. Silver Spring Md.</u> DATE SIGNED <u>2/25/60</u>			
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.			
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>			
22a. BURIAL, CREMAT. OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>ENTOMBMENT</u>	<u>2/29/60</u>	<u>FT. LINCOLN MAUSOLEUM</u>	<u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Humphrey, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Frawe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2121

CERTIFICATE OF DEATH

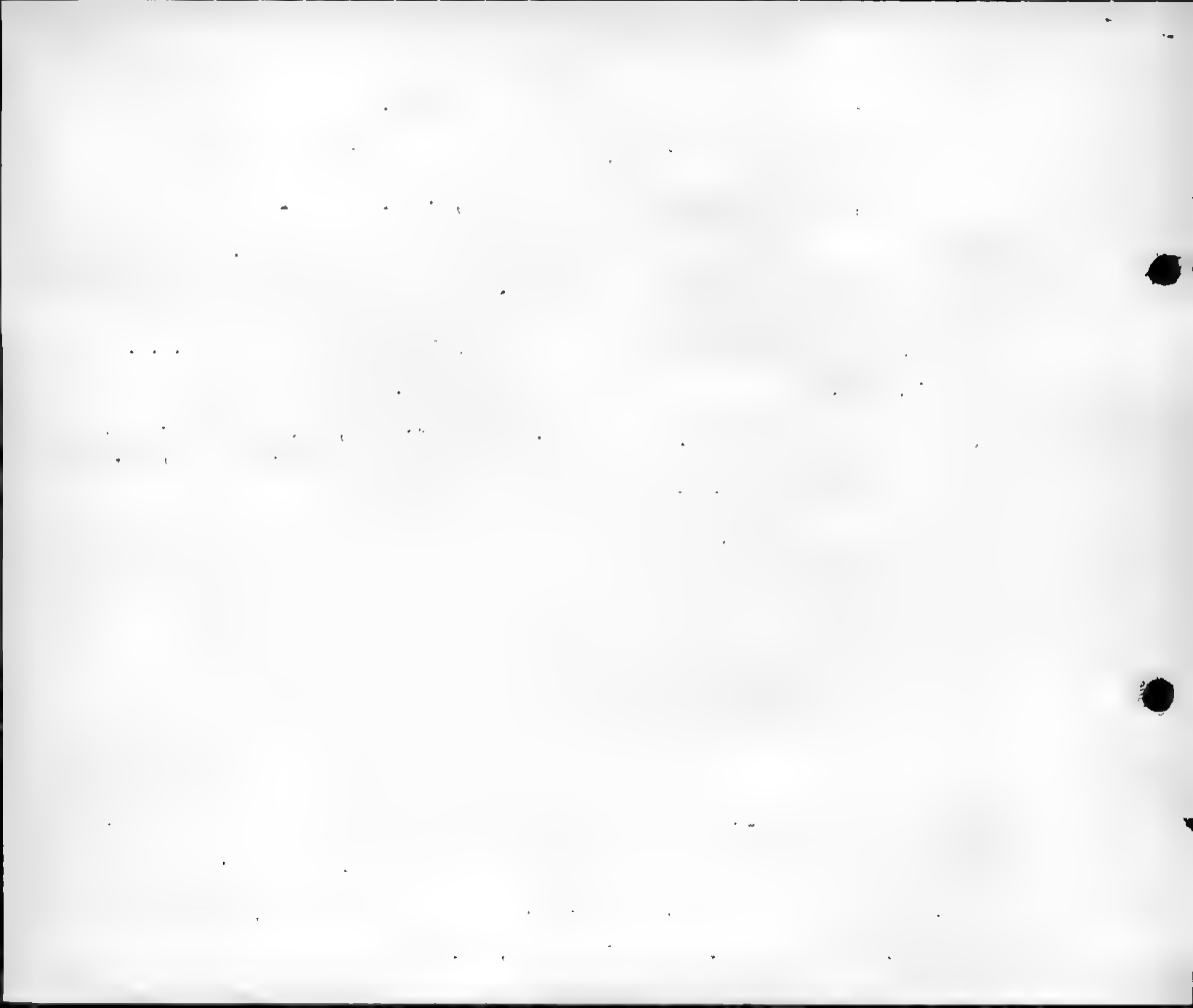
02196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,903 Hathaway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle BELLE Last LEWIS		4. DATE OF DEATH Month FEB. Day 23 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/66
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT M. DAWSON		14. MOTHER'S MAIDEN NAME ROBERTA C. MINTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Estelle Hodgson, 12,903 Hathaway Drive Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Hypostatic Pneumonia DUE TO Sensility (c) Sensility INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/26 , 19 58 , to 2/23 , 19 60 , that I last saw the deceased alive on 2/1 , 19 60 , and that death occurred at 12:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9321 Georgian Ave. Silver Spring Md DATE SIGNED			
ACTUAL SIGNATURE N.T. Lucius		M.D. 9321 Georgian Ave. Silver Spring Md	
PHYSICIAN'S NAME (Type) N.T. LUCIUS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/26/60	22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY	22d. LOCATION (City, town, or county) (State) ALEXANDRIA, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Richard W. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transmit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2172 CERTIFICATE OF DEATH

Reg. Dist. No. 02195

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN</u>				d. STREET ADDRESS <u>2942 NEWARK ST. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence E. L'Honnigedieu</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-20-1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BROOKLYN, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WM. CORNWELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY REGUAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no of unknown) <u>NC</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>578-10-1697</u>		17. INFORMANT <u>Mr. Samuel J. L'Honnigedieu</u> Address <u>7734 McFarland St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO <u>Anterior cross</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubital ulcers, senility</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb-2</u> , 1950, to <u>Feb-2</u> , 1960, that I last saw the deceased alive on <u>2 February</u> , 1960, and that death occurred at <u>1240 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4817 Lenox Ave. NW Wash D.C.</u>				DATE SIGNED <u>Feb 8 '60</u>			
ACTUAL SIGNATURE <u>Joseph H. Cowan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JOSEPH H. COWAN</u>				<u>WASHINGTON 8 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hamlet Prince Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>Feb 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fennel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02197

2239

CERTIFICATE OF DEATH

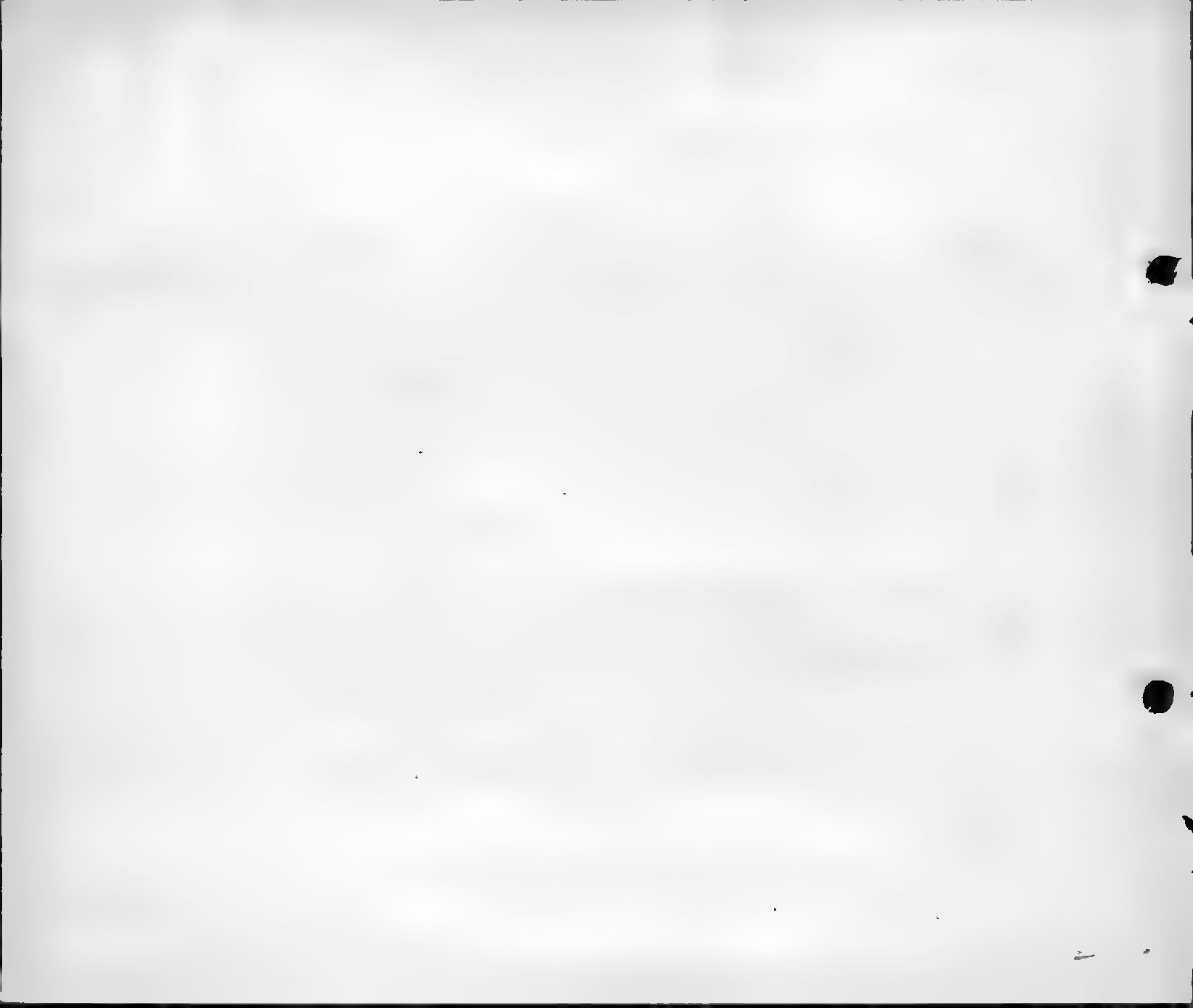
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Stephen M. Lincher</u>				4. DATE OF DEATH <u>Sept 18, 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>31</u> yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY		9c. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		9d. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10. FATHER'S NAME <u>Hugust Voigt</u>				11. MOTHER'S MAIDEN NAME <u>...</u>			
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				13. SOCIAL SECURITY NO. <u>...</u>			
14. INFORMANT <u>Mrs. P. M. ...</u>				15. ADDRESS <u>...</u>			
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X Virus Influenza (Epidemic)</u> DUE TO <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture left femur</u> DUE TO <u>3 weeks</u> (c) <u>Gen. ant. Sclerosis + Sensitivity</u> DUE TO <u>8 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3 Feb</u> , 19 <u>60</u> , to <u>8 Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 Feb</u> , 19 <u>60</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney, Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>				DATE SIGNED <u>8 Feb 60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 10, 1960</u>		<u>Prospect Hill Cemetery</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll St NW DC</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 215

02198

2240

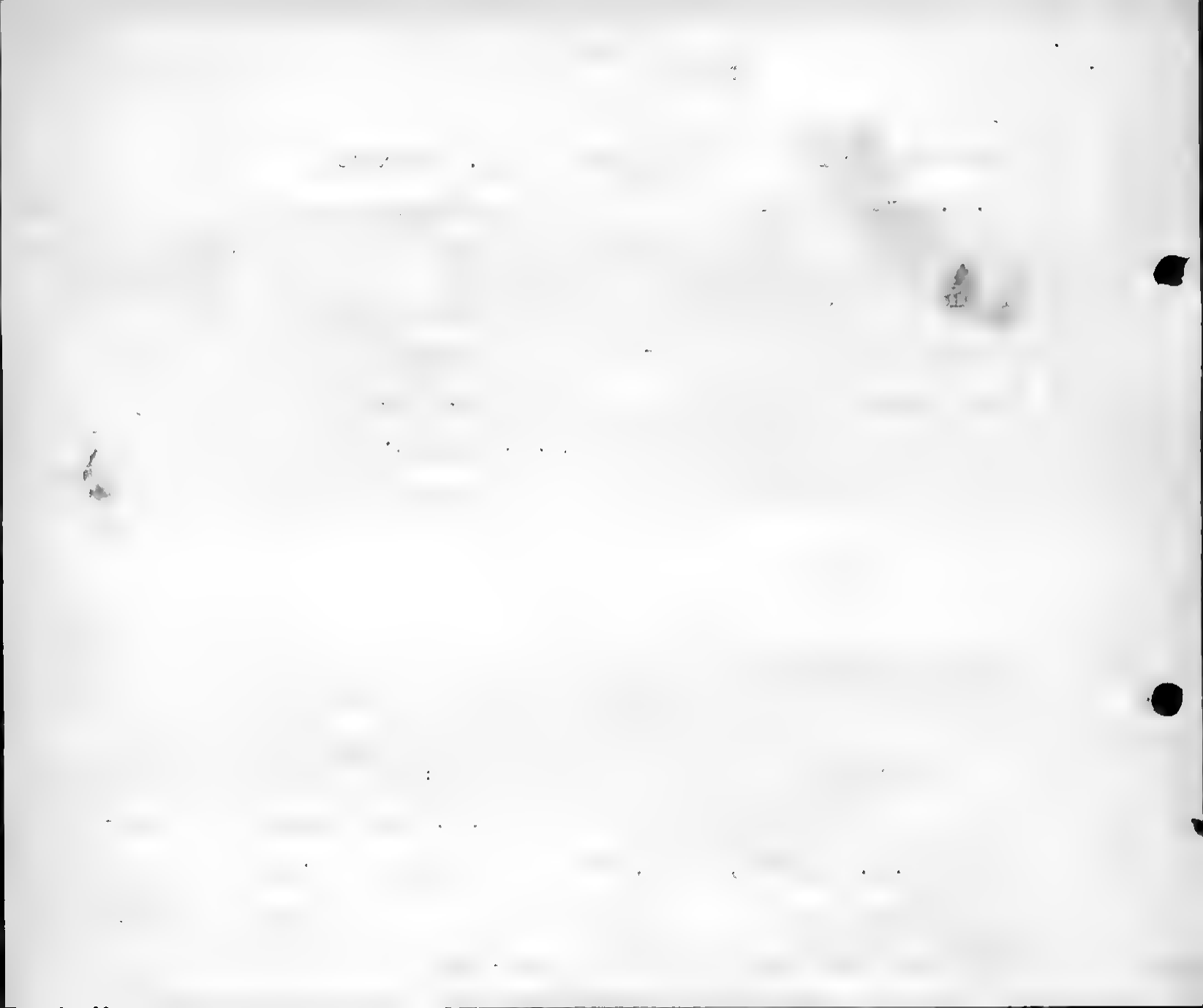
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived (If institution, Residence before admission) a. STATE Florida b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Lauderdale d. STREET ADDRESS 1325 NE 16th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Lela Middle Macie Last LINGLE			4. DATE OF DEATH Month February Day 4 Year 19 60				
5 SEX Female	6. COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-13	9 AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Florida			
12 CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Otha BROWN				
14. MOTHER'S MAIDEN NAME Dollie Horn			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. 266-14-9661			17. INFORMANT (H) F. J. Lingle, same as #2 above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of The Thyroid DUE TO 194X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) February 4, 1960			
20f. (City or town) Bethesda		20g. (County) Montgomery		20h. (State) Maryland			
21. I certify that I attended the deceased from January 9, 1960 to February 4, 1960 , that I last saw the deceased alive on February 4, 1960 , and that death occurred at 10:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Galbraith		M.D. U. S. Naval Hospital		DATE SIGNED 2-4-60			
PRINTED NAME (Type) R. G. GALBRAITH, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 2-5-60		22b. DATE THEREOF 2-5-60		22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery			
22d. LOCATION (City, town, or county) Live Oak		22e. (State) Florida		22f. (Country) USA			
23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home		ADDRESS Chevy Chase Funeral Home, 5103 Wisc. Ave., NW, WDC		24a. REC'D BY REGISTRAR FEB 8 60			
24b. REGISTRAR'S SIGNATURE Arthur A. Thomas		24c. (City, town, or county) Bethesda					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER

Signature of Frank J. Broschart

Signature of Frank J. Broschart

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

2-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

W. H. Chambers Co. Inc. 3672 17 St NW Wash, DC

DATE MAR 1 '60

Signature of Arthur S. Hume

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1
DUE TO (c)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

INTERVAL BETWEEN ONSET AND DEATH
Sudden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
NO NONE NONE

16. SOCIAL SECURITY NO.

17. INFORMANT

Address
706 Chestnut St
Dallas Texas Tex

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
D.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.C.

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

8. DATE OF BIRTH

67 yrs.

26 1960

NAME OF DECEASED (Type or print)

First

Middle

Last

DATE OF DEATH

Month

Day

Year

10000 Southerland Dr

29 yrs

10000 Southerland Dr

10000 Southerland Dr

10000 Southerland Dr

10000 Southerland Dr

10000 Southerland Dr

10000 Southerland Dr

10000 Southerland Dr

10000 Southerland Dr

1. PLACE OF DEATH
a. COUNTY

Montgomery

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE

md

b. COUNTY

Montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

d. STREET ADDRESS

d. STREET ADDRESS

d. STREET ADDRESS

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4-10-1892

67 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH

INTERVAL BETWEEN ONSET AND DEATH



2148 CERTIFICATE OF DEATH

Reg. Dist. No.

02200

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>23 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Wash Ave & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Simon</u> Middle <u>(NMN)</u> Last <u>MALINSKY</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>17</u> - Year <u>1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-27-76</u>
9 AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Ret</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer. USA</u>	
13. FATHER'S NAME <u>GERSHAN Malinsky</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-03-9863</u>	
17. INFORMANT <u>1st Chast in Hosp</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>terminal heart failure</u> DUE TO (b) <u>generalized arteriosclerosis</u> Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/12/1960</u> to <u>2/17/1960</u> that I last saw the deceased alive on <u>2/17</u> , 19 <u>60</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Arthur J. Wilets</u> M.D.		ADDRESS (Street, city or town, state) <u>909 FERSHING DR. SS9 Md.</u> DATE SIGNED <u>2/17/60</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cem</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Soldberg Funeral Home</u> ADDRESS <u>4217 94th Ave D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>



CERTIFICATE OF DEATH

02201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bessey</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>2013 Glenn Ross Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>Seddon</u> Middle <u>Marston</u> Last				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 13-1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min <u>75</u>		IF UNDER 24 HRS Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min <u>75</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Etna Mills - Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Patrick Henry Eubank</u>				14. MOTHER'S MAIDEN NAME <u>Sally Kerr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>If yes, give war or dates of service</u>				16. SOCIAL SECURITY NO. <u>Wasp. Records</u>			
17. INFORMANT <u>Wasp. Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE SUBARACHNOID MEM.</u> DUE TO <u>Sen. Arteriosclerosis + Scurvy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>10 yrs</u> (b) <u>10 yrs</u> (c) <u>10 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 21-1958</u> to <u>26 Feb-1960</u> , that I last saw the deceased alive on <u>26 Feb-1960</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.							
ATTENDING SIGNATURE <u>John Bosley Ziegler M.D.</u>				ADDRESS (Street, city or town, state) <u>ORNEY, MD</u>			
DATE SIGNED <u>26 Feb 60</u>							
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Massanutten</u>		22d. LOCATION (City, town, or county) (State) <u>Woodstock VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. L. Billinger</u>				ADDRESS <u>Woodstock, Va</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2173

CERTIFICATE OF DEATH

02202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		/ d. STREET ADDRESS 5115 Wessling Lane	
3. NAME OF DECEASED (Type or print) First Ida Middle F. Last McCarthy		4. DATE OF DEATH Month Feb Day 2 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1884
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR: Months 4 Days 25 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sweeney		14. MOTHER'S MAIDEN NAME Sarah Logan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William J. McCarthy, Jr. - Item #2 - Son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory Failure 170x DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic - Carcinomatosis (Breast) DUE TO (c) two years		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 30 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 55 to February 2 19 60 , that I last saw the deceased alive on February 1 19 60 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Jagers Jr. M.D.		ADDRESS (Street, city or town, state) 5707 WISCONSIN AVE DATE SIGNED 2/2/60	
PHYSICIAN'S NAME (Type) Frank Jagers Jr. M.D.		CHEVY CHASE 15, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Bur-Trans.	22b. DATE THEREOF 2-4-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	22d. LOCATION (City, town, or county) (State) Bangor, Maine
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2242
CERTIFICATE OF DEATH

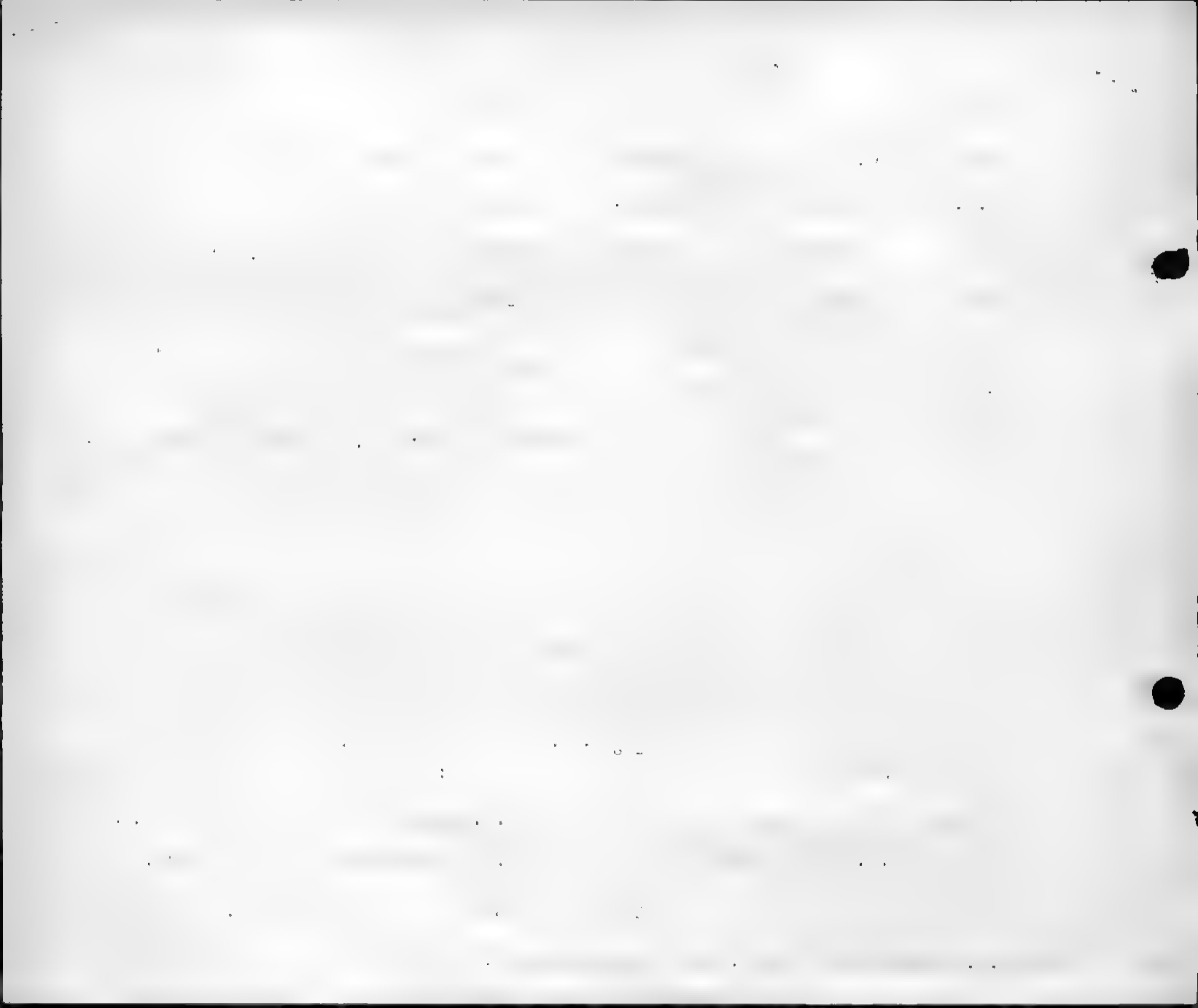
Reg. Dist. No. 215

02203

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 34 days		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		d. STREET ADDRESS 10505 Malone Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Adrey Last MC CULLAH		4. DATE OF DEATH Month February Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-07
9. AGE (In years lost birthday) 52		10. IF UNDER 1 YEAR Months 5 Days 2 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fred GANT		14. MOTHER'S MAIDEN NAME Evelyn BARBER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (Husband) Harry F. MC CULLAH Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast with metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 22 January 1960 to 25 February 1960 , that I last saw the deceased alive on 25 February 1960 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE E.J. Rupnik M.D. U.S. Naval Hospital, Bethesda Md. 2-26-60 PHYSICIAN'S NAME (Type) E.J. RUPNIK LCDR MC USN U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-1-60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES		24a. REC'D BY REGISTRAR DATE FEB 29 1960	24b. REGISTRAR'S SIGNATURE C. L. Hines

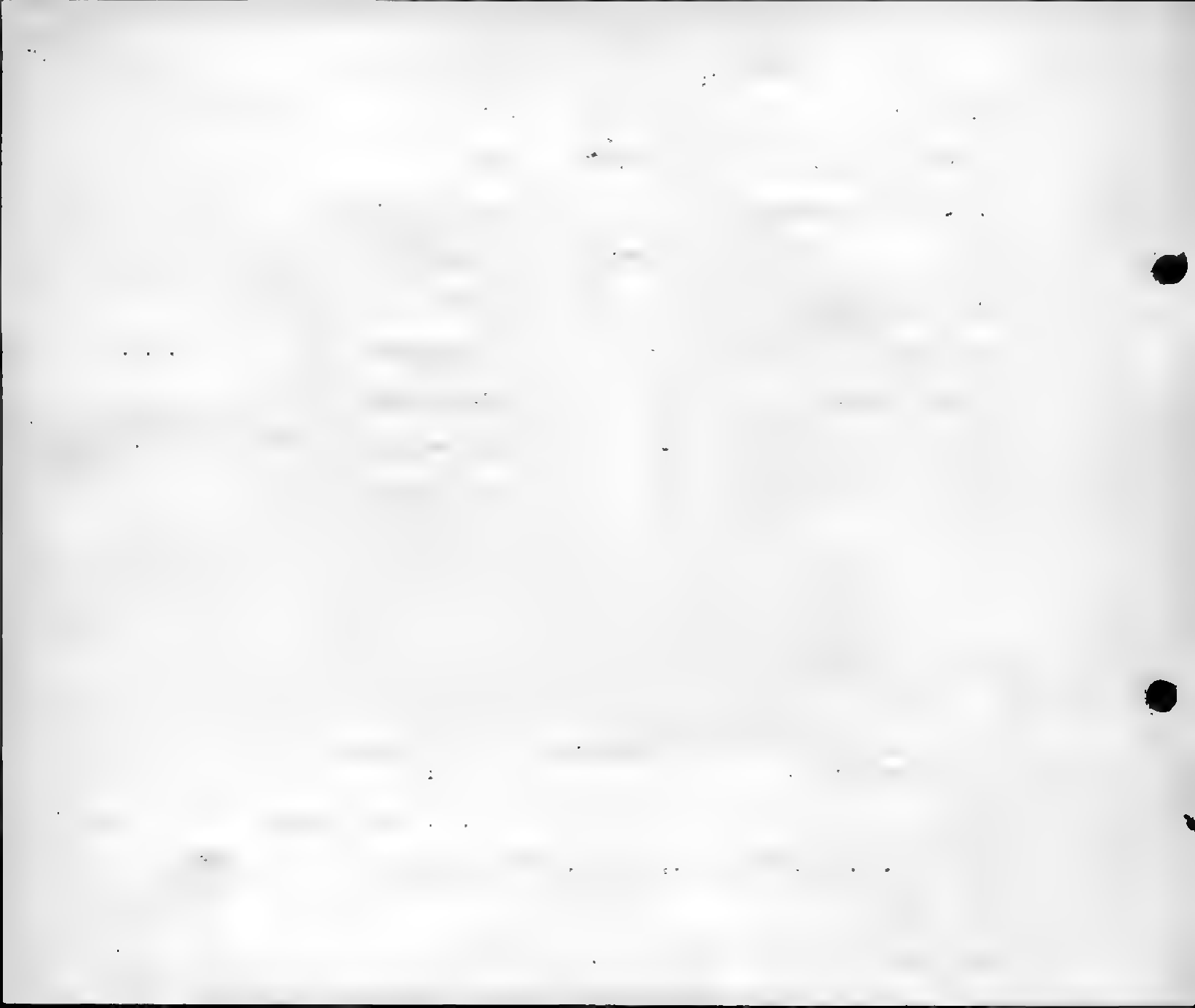
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 259 3-31-60 4MS										
2243										
CERTIFICATE OF DEATH										
Reg. Dist. No. 215										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x d. STREET ADDRESS 3916 4th Street N. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Estella Middle Mary Last MC DERMOTT					4. DATE OF DEATH Month February Day 15 Year 1960					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-76		9. AGE (In years last birthday) 83		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William BUSBY					14. MOTHER'S MAIDEN NAME Bridget WELSH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT (D) Katherine Herrold, Trotter Rd. Rt. 29					Address Clarksville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 10th DIVISION 10th DIVISION 10th DIVISION Diverticulosis and diverticulitis with abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 10th DIVISION 10th DIVISION 10th DIVISION and perforation of descending colon. DUE TO (c) 10th DIVISION 10th DIVISION 10th DIVISION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Fargo		(County) (State)		
21. I certify that I attended the deceased from February 13, 1960 to February 15, 1960 , that I last saw the deceased alive on February 15, 1960 , and that death occurred at 8:57A , from the causes and on the date stated above.										
ACTUAL SIGNATURE R. G. Galbraith, Jr.					ADDRESS (Street, city or town, state) U. S. Naval Hospital					
DATE SIGNED 2-15-60										
PHYSICIAN'S NAME (Type) R. G. GALBRAITH, JR., LT, MC, USN Bethesda 14, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 2-16-60		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town or county) Fargo		(State) No. Dakota		
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd. Arlington, Va.					24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

02204



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 6258 3-8-60 et

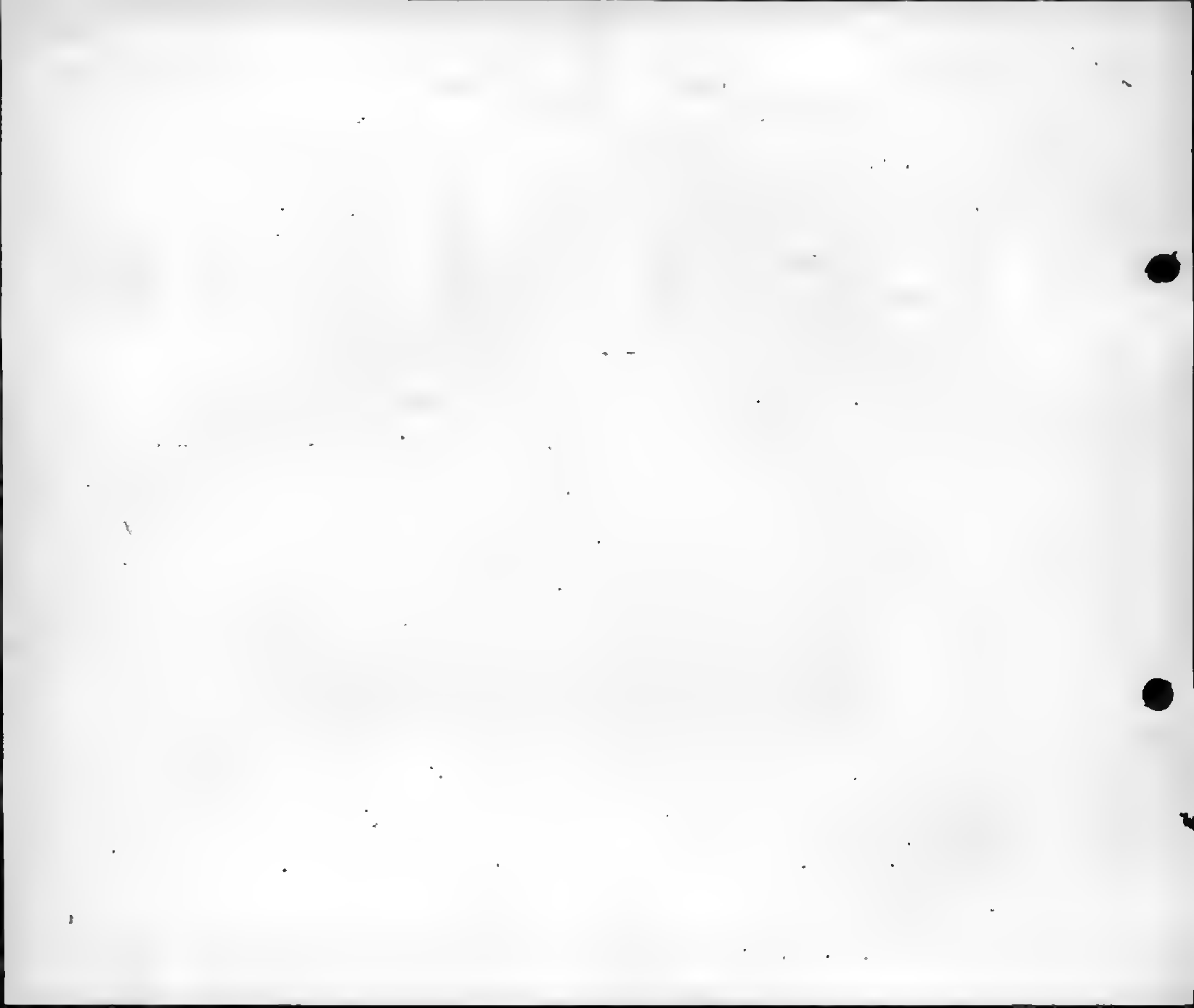
CERTIFICATE OF DEATH

02205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1609 Sanford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Isabel McElroy First Middle Last		4. DATE OF DEATH February 22 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1873
9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR: Months 7 Days 17 Hours 17 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Ben F. Sheffer, Benjamin F.		14. MOTHER'S MAIDEN NAME Mary Elkin, Margaret	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 57-32-7101 Unknown INFORMANT Miss Olive McElroy-daughter-same 2d Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Right hemiplegia INTERVAL BETWEEN ONSET AND DEATH 6 hours 1 year 2 years			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from March 23 1959 to Feb 22, 1960 , that I last saw the deceased alive on Feb 22 1960 , and that death occurred at E. P. M. from the causes and on the date stated above. ACTUAL SIGNATURE John J. Fawcett M.D. Dawsonville, P.O. Bayds, Ind PHYSICIAN'S NAME (Type) John J. Fawcett Dawsonville, Md. Feb 23 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 2/24/60	22b. DATE THEREOF 2/24/60	22c. NAME OF CEMETERY OR CREMATORY Homewood Cemetery	22d. LOCATION (City, town, or county) Pittsburgh, Pennsylvania (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 26 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur E. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

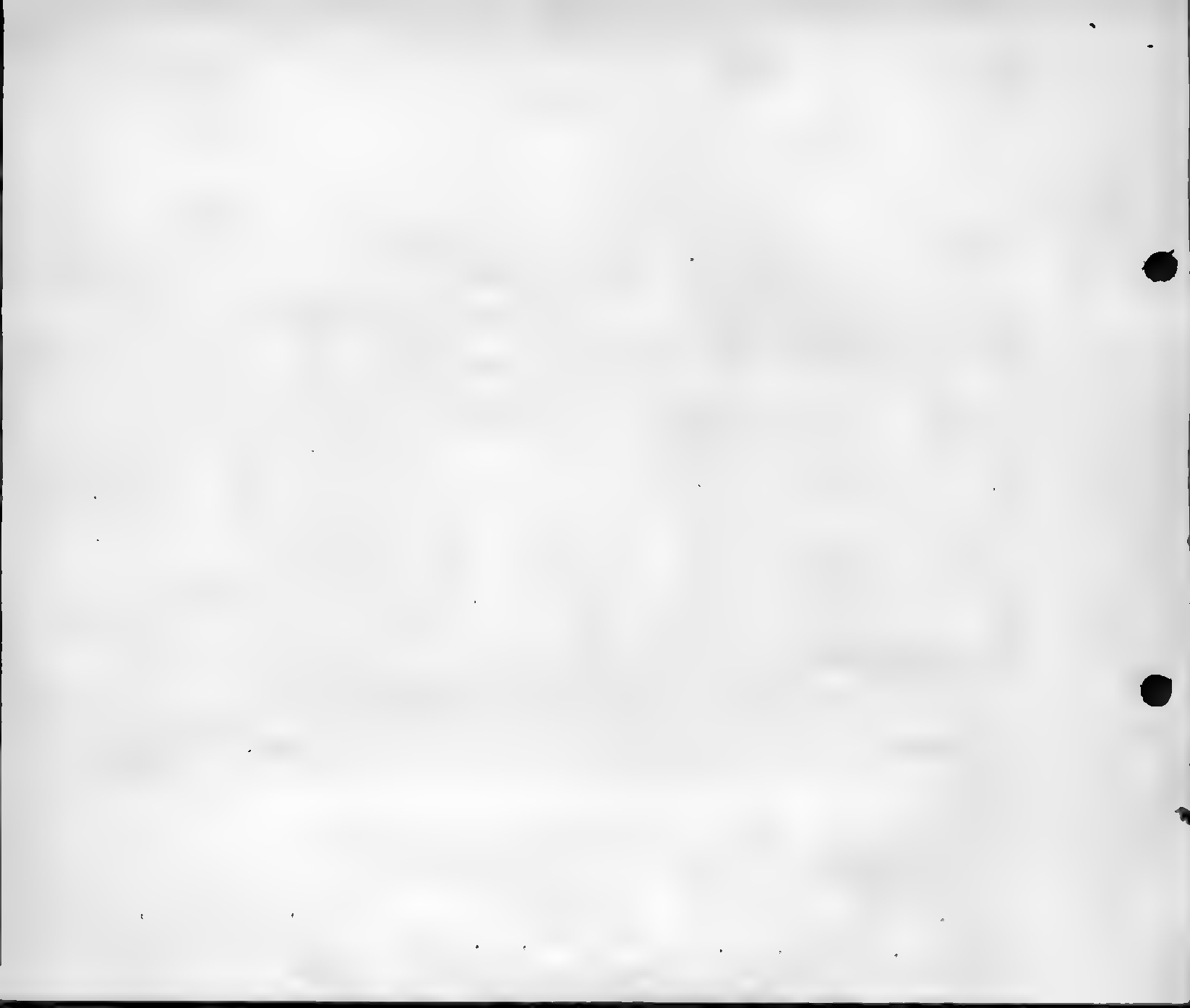
02206

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ednor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>9 mo</u>		d. STREET ADDRESS <u>7400 25th Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethmont Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> A. Middle <u>McKechanic</u> Last <u>McKechanic</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of life. If retired, state so.) <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Ill</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Moran</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Lypson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Nursing Home Record - Sister 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized atherosclerosis</u> (c) <u> </u> DUE TO <u> </u> cause lost. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-9-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 2/9/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EVANSTON, COOK COUNTY, ILLINOIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER. Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



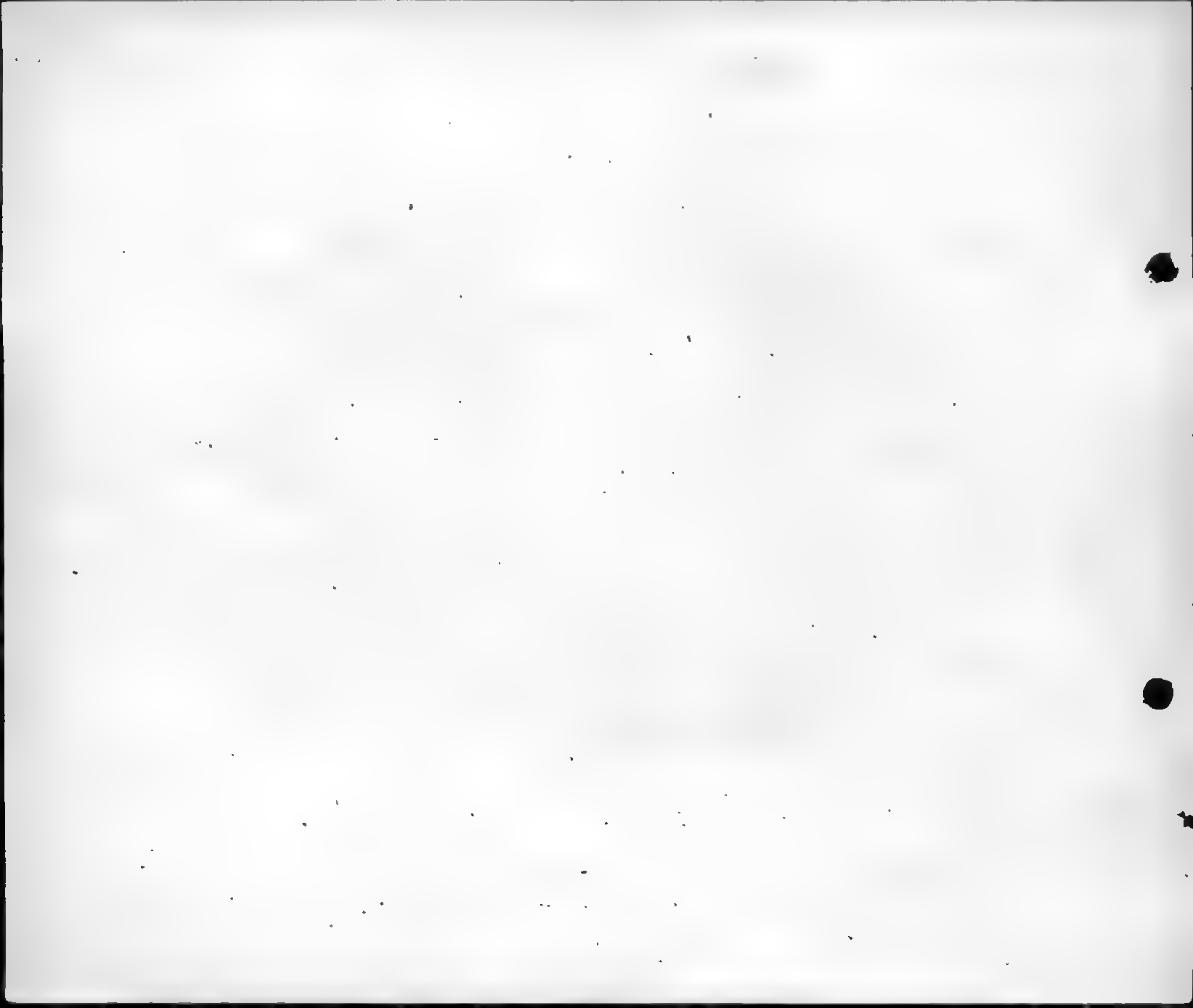
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Buchanan</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>(4 years)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Santurin</u>		d. STREET ADDRESS <u>9200 Wisconsin Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>V</u> Last <u>Molecki</u>		4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/1867</u>
9. AGE (In years last birthday) <u>91 1/2</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>12</u> Hours <u>0</u> Min <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11c. BIRTHPLACE (State or foreign country) <u>Buchanan, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Finney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lee Martin</u>		Address <u>5521 Columbia Ave NW Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Unal Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis with</u> (c) <u>right sided facial paralysis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Semility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 12, 1956</u> to <u>Feb 23, 1960</u> that I last saw the deceased alive on <u>Feb 22, 1960</u> and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive, Silver Spring, Md.</u> DATE SIGNED <u>2/23/60</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/25/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT CENT. ARLINGTON VA.</u>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u> ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>Feb 25 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

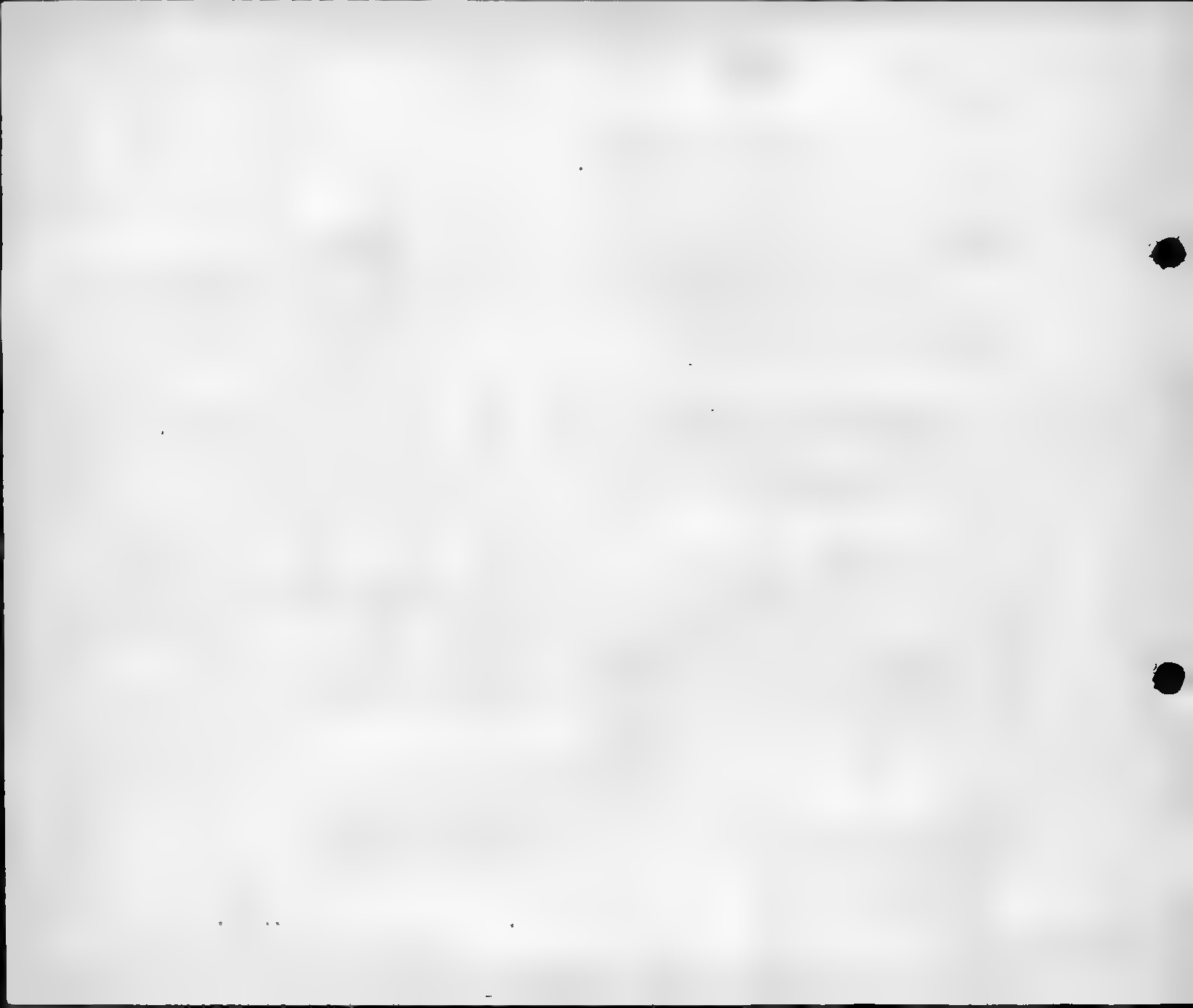
Reg. Dist. No.

02208

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Jay Meister</u>				4. DATE OF DEATH Month Day Year <u>2 - 23 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-09</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Sarah (unknown)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>215-10-7142</u>		17. INFORMANT <u>Mrs. Alice Elizabeth Meister</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Dickner</u>				24a. REC'D BY REGISTRAR <u>DATE 25-60</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Dickner</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 3/8 3-9-60 et

CERTIFICATE OF DEATH

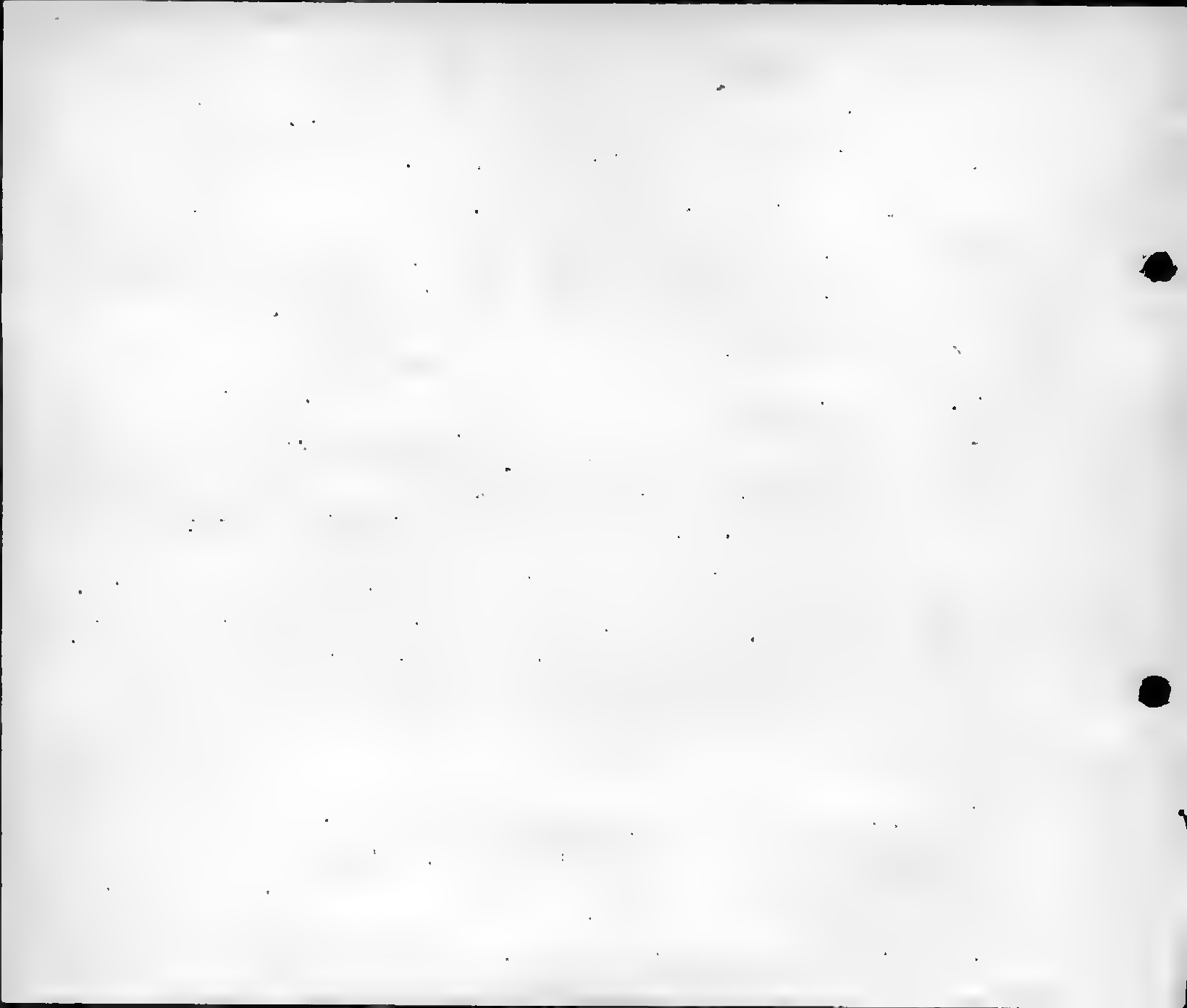
02209

Reg. Dist. No.

2247

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Washington b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.		d. STREET ADDRESS 5623 First St. N.W.	
3. NAME OF DECEASED (Type or print) Nellie First MERRITT Middle Last		4. DATE OF DEATH Feb. 17 19 60 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10, 1884
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR: Months 1 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALEX JAMES		14. MOTHER'S MAIDEN NAME FANNIE BECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 1475 MARGARET CHEASON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of intestinal contents (c) Septicemic venous thrombosis-infection		INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary stenosis - mitral insufficiency - myocardial hypertrophy - arteriosclerotic		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part 1 of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 17 19 60 , to Feb 17 19 60 , that I last saw the deceased alive on Feb 17 19 60 , and that death occurred at 12:05 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 13000 94th AVE DATE SIGNED Feb 19 1960			
ACTUAL SIGNATURE P. L. Tabb, M.D.			
PHYSICIAN'S NAME (Type) S. L. TABB, M.D.			
22a. BURIAL, CREMATION REMOVAL (Specify) Transportation		22b. DATE THEREOF 2/18/60	
22c. NAME OF CEMETERY OR CREMATORY Augusta		22d. LOCATION (City, town, or county) (State) Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR FEB 19 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2248
CERTIFICATE OF DEATH

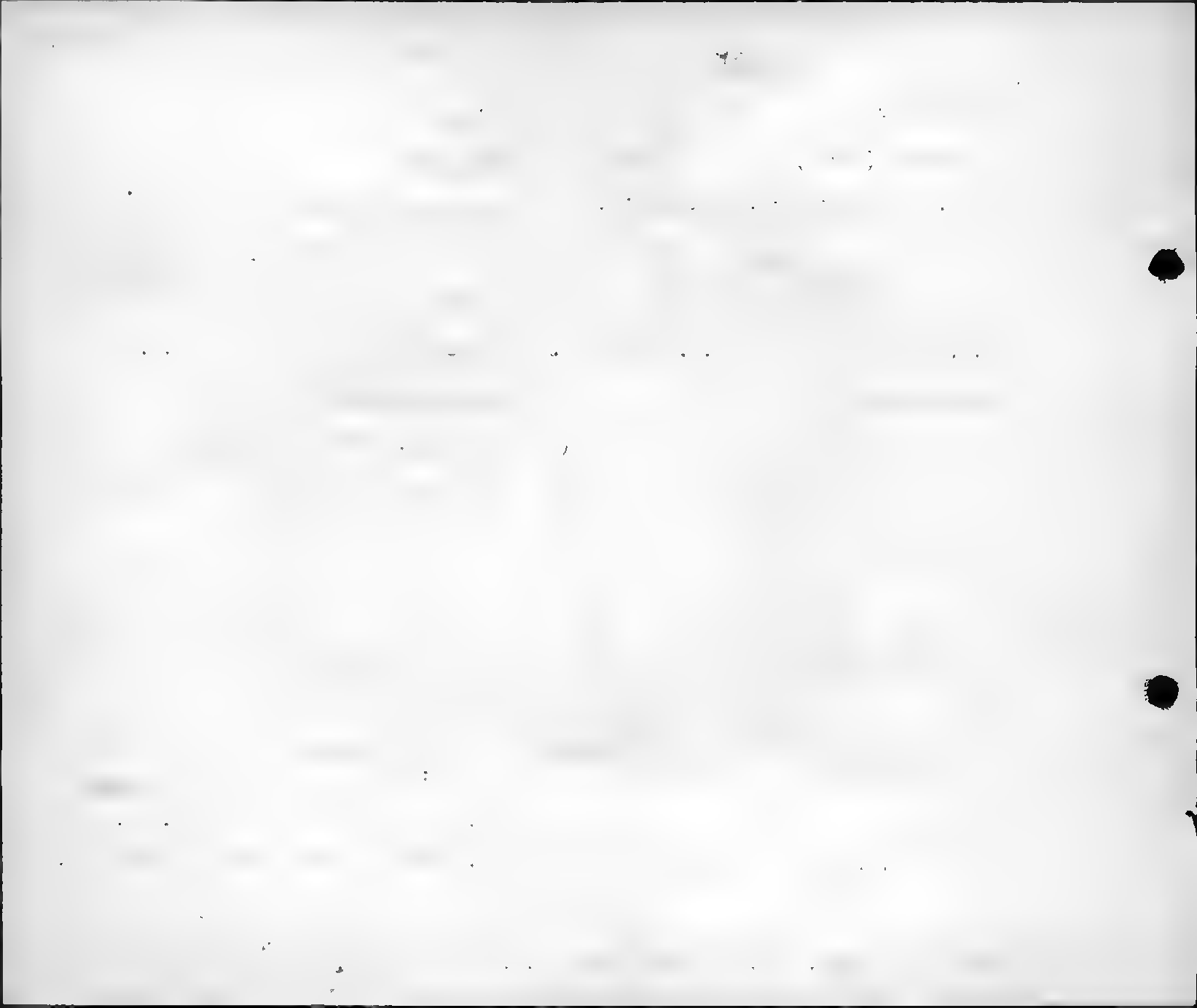
Reg. Dist. No. 215

02210

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6105 Clearfield Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Edgvert Last METTS		4. DATE OF DEATH Month February Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-07
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months 3 Days 2 Hours 0 Min. 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Horace METTS		14. MOTHER'S MAIDEN NAME Hattie DONALDSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) VV II		16. SOCIAL SECURITY NO. INFORMANT (Wife) Marie U. METTS Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar Artery Thrombosis 3:22X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 17 February, 19 60 , to 29 February, 19 60 , that I last saw the deceased alive on 29 February, 19 60 , and that death occurred at 10:05AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James M Brown		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 3-1-60	
PHYSICIAN'S NAME (Type) J.M. BROWN LT MC USN		U.S. Naval Hospital, NNMC, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-3-60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE Lee 4th and Mass. Ave. N.W. Washington D.C.		24a. REC'D BY REGISTRAR DATE MAR 2 '60	24b. REGISTRAR'S SIGNATURE Carlton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1b & c of Form 3-58 3-1-60 1wk

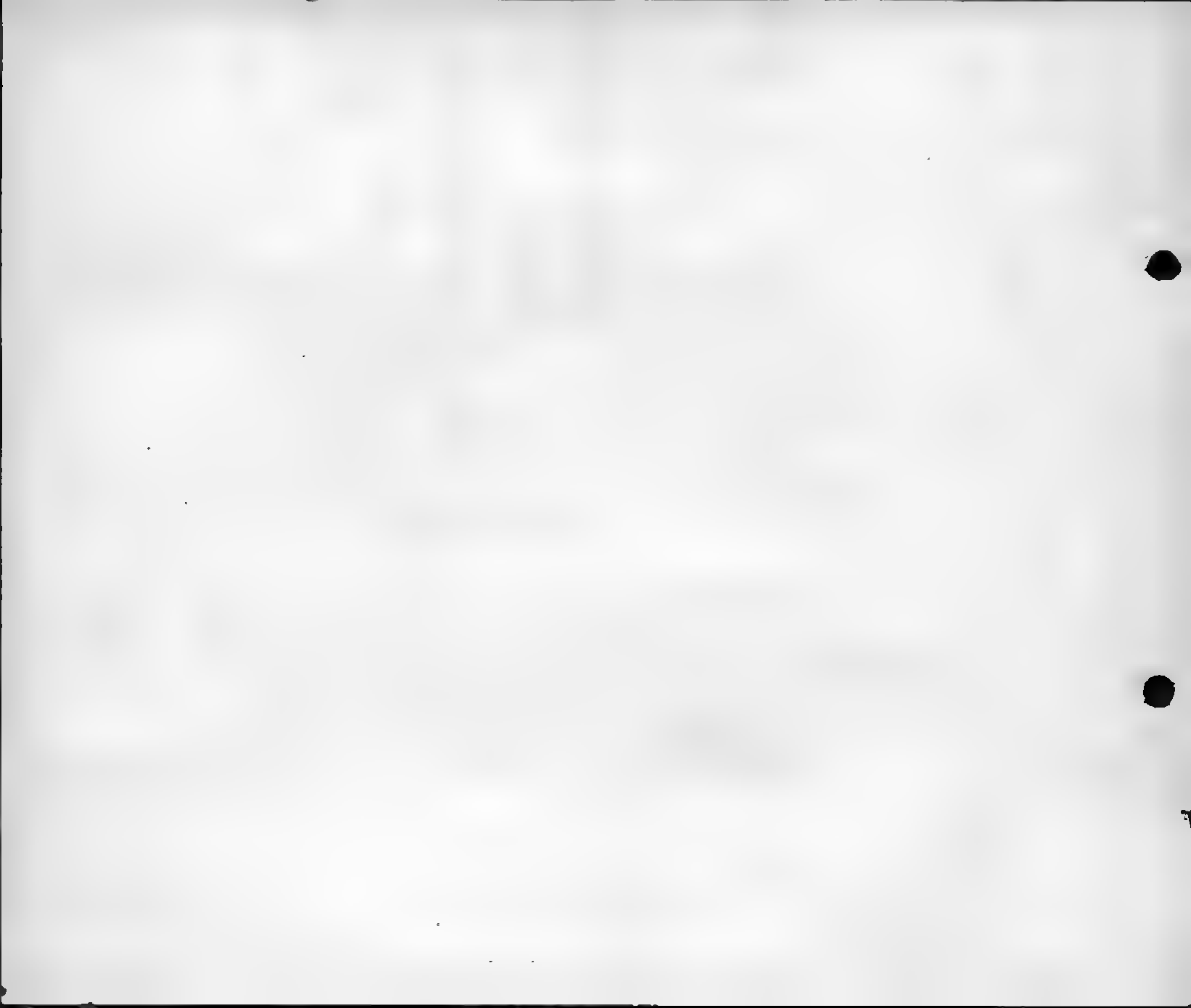
CERTIFICATE OF DEATH

2249

Reg. Dist. No.

02211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Md.				c. LENGTH OF STAY IN TB X Wheaton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION h r residence-13300 Georgia Avenue				e. STREET ADDRESS 13300 Georgia Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maud E Meyer				4. DATE OF DEATH Month February Day 28 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1893	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Berkeley				14. MOTHER'S MAIDEN NAME Elizabeth Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 13300 Ga. Ave			
17. INFORMANT Dorothea E. Marek				Address 13300 Ga. Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM, LEFT Lung. 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombus LEFT RIGHT ATRIUM DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/27 , 19 60 , to 2/28 , 19 60 , that I last saw the deceased alive on 2/27 , 19 60 , and that death occurred at 2:00 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 13018 Georgia Ave Silver Sp Md DATE SIGNED 2/28/60 ACTUAL SIGNATURE A.W. Smith PHYSICIAN'S NAME (Type) A.W. SMITH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.	
22d. LOCATION (City, town, or county) (State) Washington D. C.				23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home			
24a. REC'D BY REGISTRAR MAR 7 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



2250 CERTIFICATE OF DEATH

02212

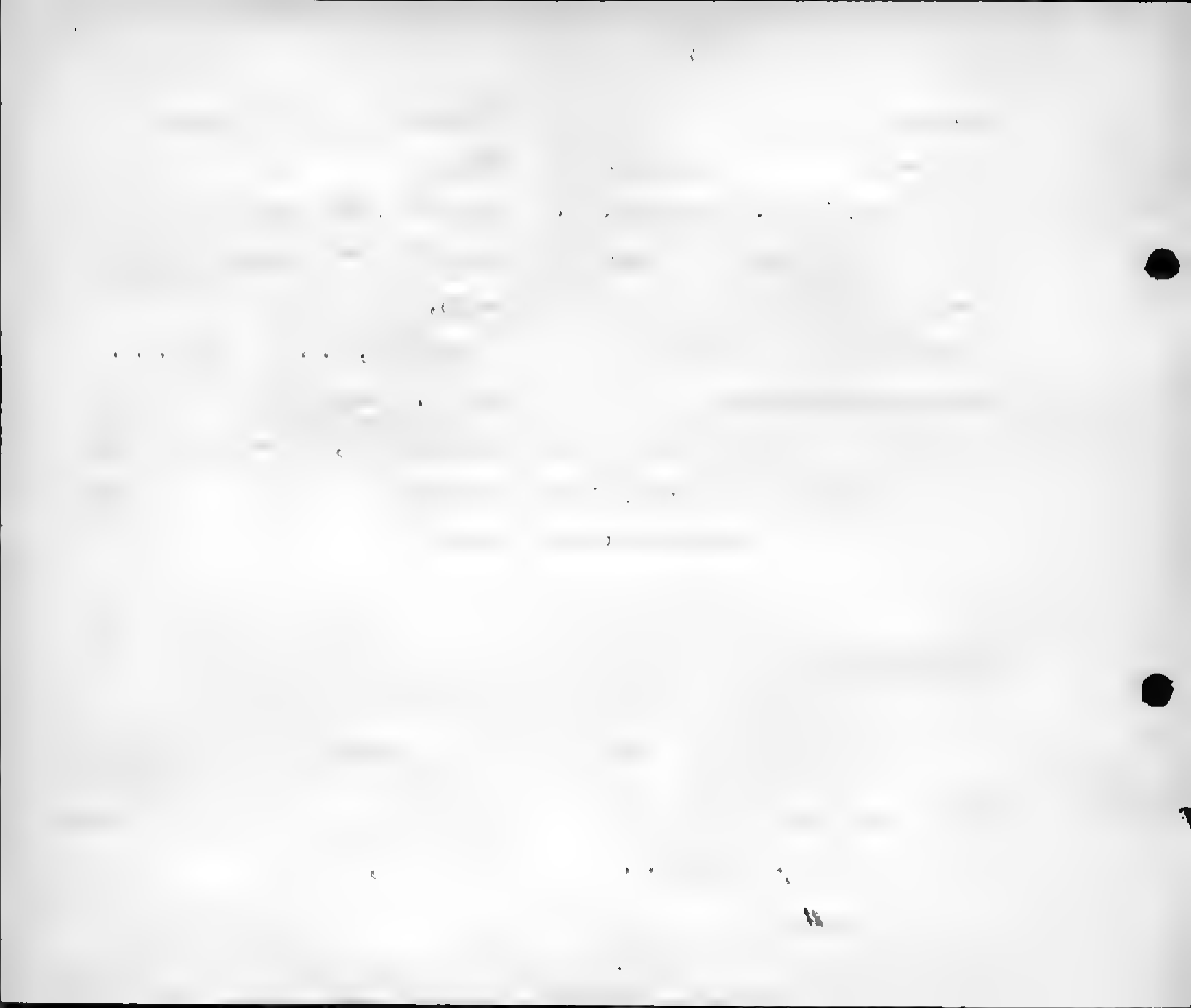
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2377 North Quincy Street			
3. NAME OF DECEASED (Type or print) First Middle Last Anna Jane Montgomery				4. DATE OF DEATH Month Day Year February 9 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1938		9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Miles Montgomery				14. MOTHER'S MAIDEN NAME Annie G. Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7, 1960 to February 9, 1960 that I last saw the deceased alive on February 9, 1960 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 2/10/60							
ACTUAL SIGNATURE Lawrence A. Gaydos		M.D. The Clinical Center					
PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.		National Institutes of Health					
		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/1960		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Romer ADDRESS Arlington, 3, Va.				24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE Charles R. Romer	
Arlington Funeral Home 3901 No. Fairfax Drive							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



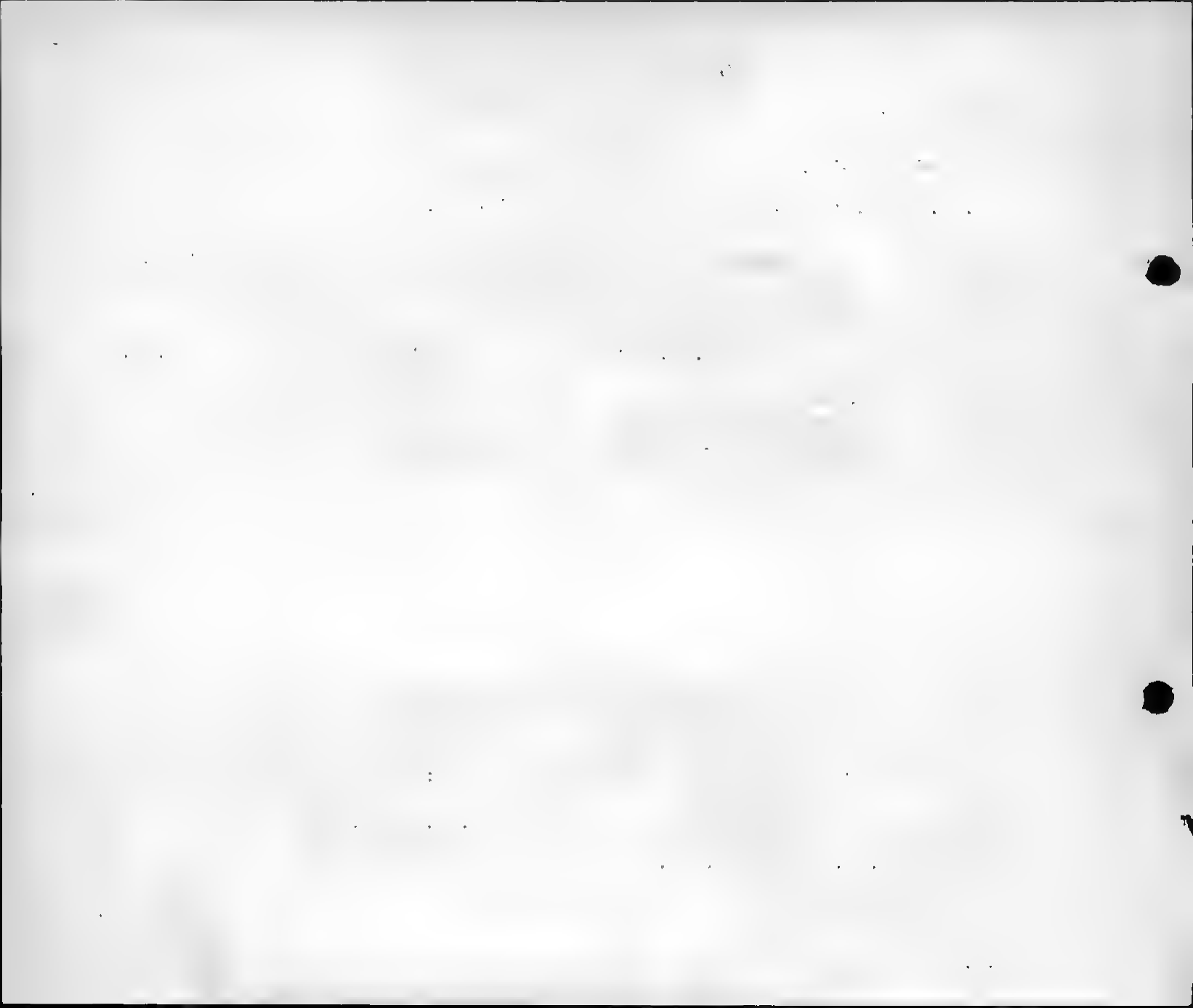
2251 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 316 days		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Tennessee		b. COUNTY Y	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene		Middle MONTGOMERY		Last MONTGOMERY		4. DATE OF DEATH Month February		Day 13	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-39		9. AGE (In years last birthday) 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William MONTGOMERY				14. MOTHER'S MAIDEN NAME Leola BROOKS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1957toDOD		16. SOCIAL SECURITY NO. 414-46-4698		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 196.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Metastatic disease DUE TO (c) Osteosarcoma of left humerus								INTERVAL BETWEEN ONSET AND DEATH 2 days 7 months 1 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 3 , 1959, to February 13 , 1960, that I last saw the deceased alive on February 13 , 1960, and that death occurred at 8:50A AM, from the causes and on the date stated above.									
ACTUAL SIGNATURE N. T. Debevoise				ADDRESS (Street, city or town, state) U. S. Naval Hospital				DATE SIGNED 2-13-60	
PHYSICIAN'S NAME (Type) N. T. DEBEVOISE, LT, MC, USN				Bethesda 14, Maryland					
22a. BURIAL, CREMATORY, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 2-16-60		22c. NAME OF CEMETERY OR CREMATORY Chattanooga National		22d. LOCATION (City, town, or county) (State) Chattanooga Tenn.			
23. FUNERAL DIRECTOR'S SIGNATURE George W. Chambers ADDRESS W.W.Chambers Co., 1400 Chapin St,NW, WashDC				24a. REC'D BY REGISTRAR DATE FEB 16 60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02214

2252

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 7 HR. 25 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. RT. #3 SHADY GROVE ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANKLIN MOORE				4. DATE OF DEATH Month Day Year FEBRUARY 20 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/97	9. AGE in years lost in day 62 yrs.	IF UNDER 1 YEAR Months Days 10 20	IF UNDER 24 HRS Hours Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATING ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. ret.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MOORE				14. MOTHER'S MAIDEN NAME TINA --- Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) WW1 1917-1918		16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosis. DUE TO (c) Chronic myocarditis, Emphysema.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 1-5-58 19 to 2-19 19 60 that (I) (we) last saw the deceased alive on Feb 19 19 60 , and that death occurred at 12:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS GAITHERSBURG, MARYLAND			
22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.		22d. ADDRESS GAITHERSBURG, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/23/60	23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery	23d. LOCATION (City, town, or county) (State) Gaithersburg, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 24 '60	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

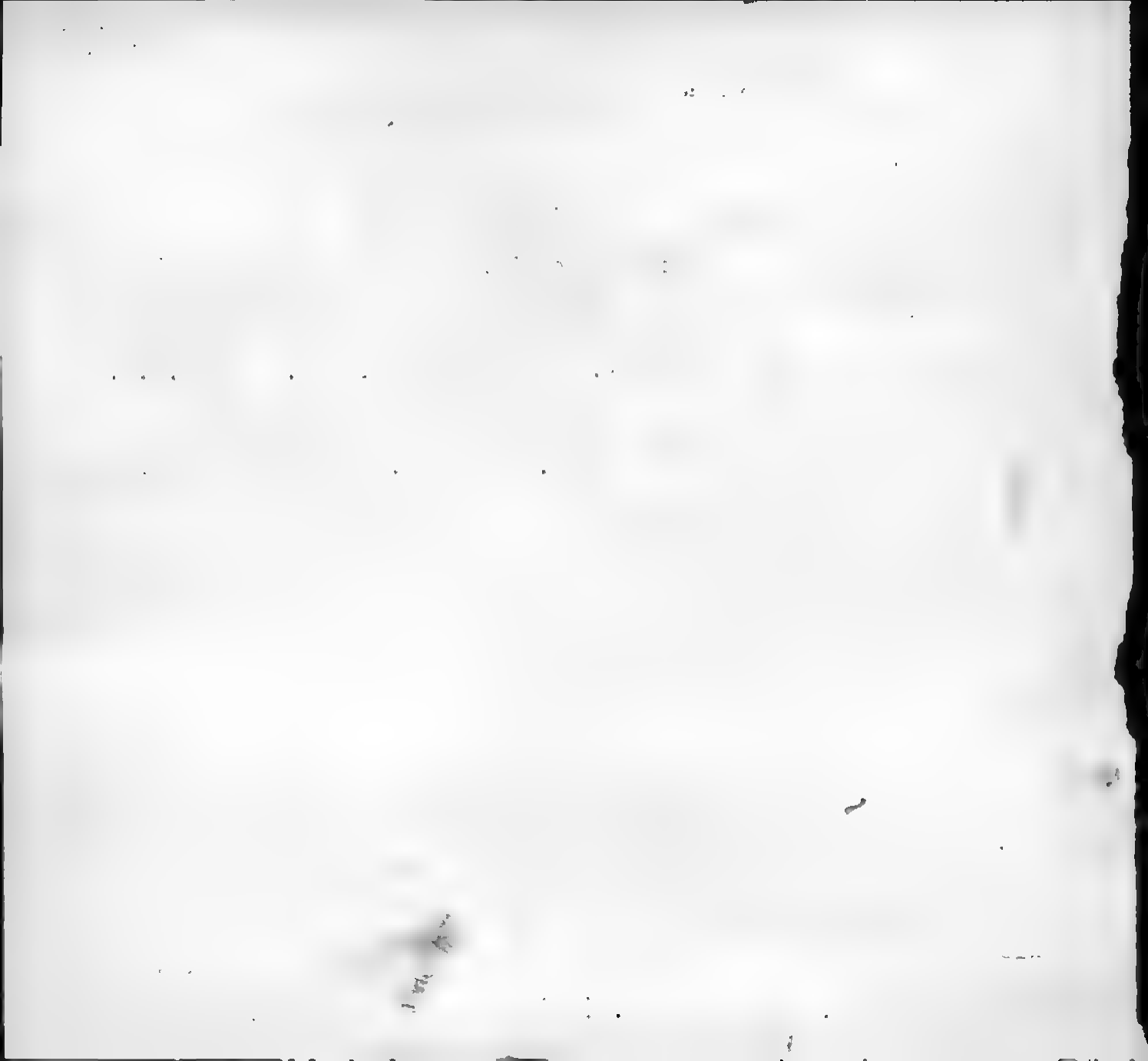
2123

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10219 Southmoor Drive				d. STREET ADDRESS 10219 Southmoor Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Paul Henry Moreland				4. DATE OF DEATH Month Feb Day 19 Year 1960			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec 15, 1888		9 AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Chief Finance		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11 BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Moreland				14. MOTHER'S MAIDEN NAME Susanna Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		INFORMANT Mrs. Miriam M. Chester		Address daughter	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (bacterial type) 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Influenza DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 WEEKS						PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AORTIC STENOSIS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 5 , 19 60 , to FEB 19 , 19 60 , that I last saw the deceased alive on FEB 19 , 19 60 , and that death occurred at 7:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1821 QUEST ST., N.W. DATE SIGNED ACTUAL SIGNATURE Harry Zehner M.D. PHYSICIAN'S NAME (Type) HARRY ZEHNER WASH. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/22/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				24a. REC'D BY REGISTRAR DATE FEB 23 1960		24b. REGISTRAR'S SIGNATURE C. S. Hines	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN TB <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4406 Amherst Dr.</u>				d. STREET ADDRESS <u>4406 Amherst Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helene</u> Middle <u>B.</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Patrick Gleason</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Steindson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Francis Donohoe - Sister</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>483X Acute Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Suppression</u> (c) DUE TO <u>Suppression</u> (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>0</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		DATE SIGNED <u>2-12-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



2124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>				c. LENGTH OF STAY IN lb <u>2301 Douglas Court Silver Spring Md</u>			
d. NAME OF HOSPITAL (If not hospital give street address) OR INSTITUTION <u>Le Beau Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> (First) <u>Murray</u> (Middle) <u>Murray</u> (Last)				4. DATE OF DEATH Month <u>2</u> - Day <u>19</u> - Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-26-88</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Artist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp</u>			
11. BIRTHPLACE (State or foreign country) <u>M. J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Murray</u>				14. MOTHER'S MAIDEN NAME <u>Mary McAloney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u> </u>				Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o m p m <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct 1958</u> to <u>Feb 19 1960</u> , that I last saw the deceased alive on <u>Feb 16 1960</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Robert T. Thibodeau M.D.</u>						<u>1669 CROOKED ST. 3/9/60</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBODEAU</u>						<u>REC'D BY REGISTRAR</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>2/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John Ave</u>		22d. LOCATION (City, town, or county) <u>Montgomery Co Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W A. Huntman & Son</u>				ADDRESS <u>5732 Ka Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 11 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6220 - 58th Ave. 16 d. STREET ADDRESS Forest Hgts, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Nelle Mae Murray		4. DATE OF DEATH Month Day Year February 13 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11, 1893
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Casson		14. MOTHER'S MAIDEN NAME MARY WOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give war or dates of service) NONE	
17. INFORMANT MRS. EDNA NAUGHTON		Address 6116 W. CHESTER DR. CAMP SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Exsanguination Esophageal Varices Portal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Abdominal Carcinomatosis (c) Ovarian Carcinoma, Primary			INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 29 1959 to Feb 13 1960, that I last saw the deceased alive on February 13 1960, and that death occurred at 6:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord Street Washington, D.C. DATE SIGNED Feb 13, 1960			
ACTUAL SIGNATURE Robert T. Thibadeau, M.D. Kensington, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-16-60	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR DATE FEB 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. *8*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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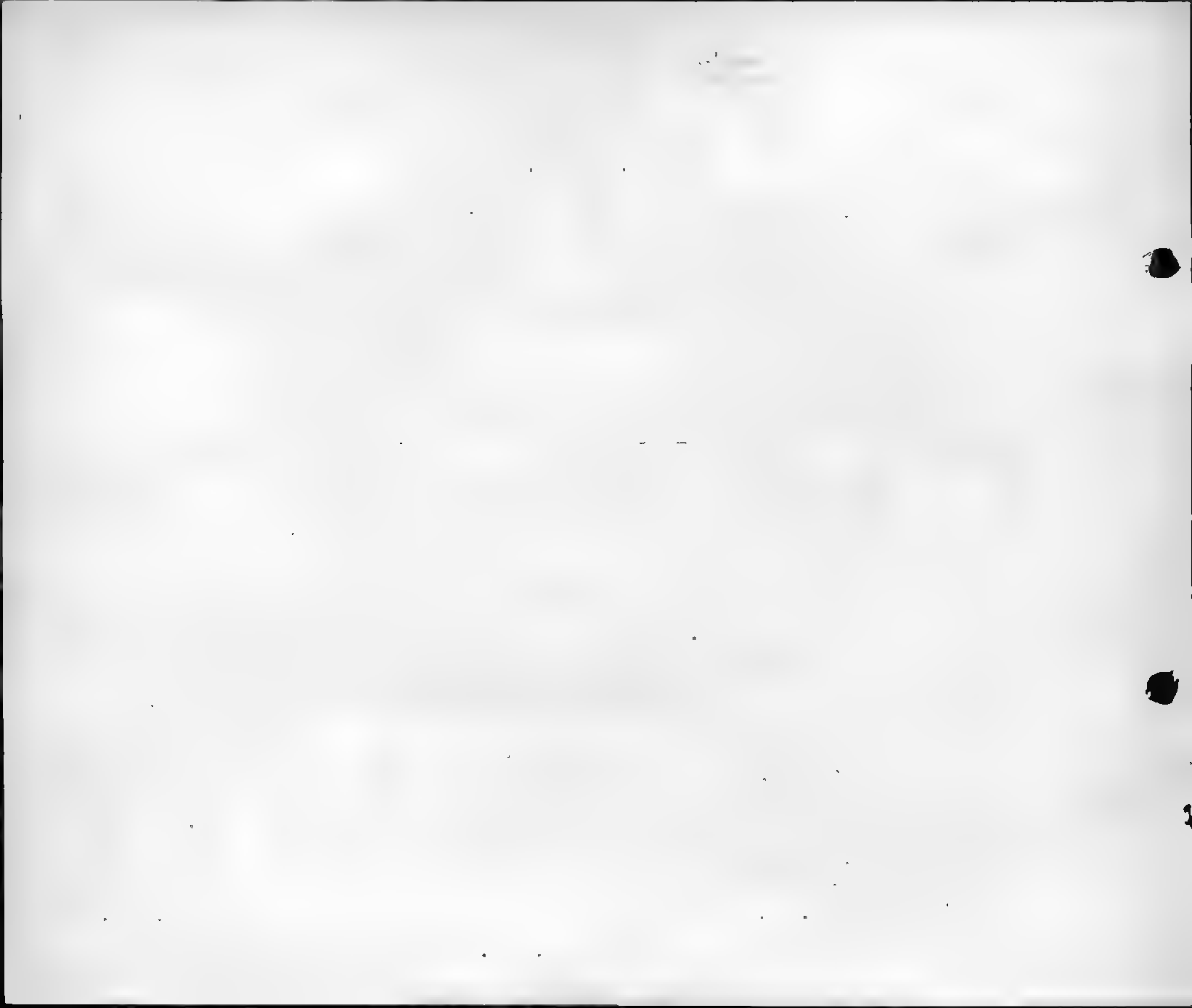
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2253 CERTIFICATE OF DEATH

02219

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 21 HR. 15 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				d. STREET ADDRESS RT. #3			
3. NAME OF DECEASED (Type or print) First HARRISON Middle BENJAMIN Last MYERS				4. DATE OF DEATH Month FEBRUARY Day 24 Year 19 60			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/87	
9. AGE (in years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES ALLEN MYERS				14. MOTHER'S MAIDEN NAME HENRIETTA FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-03-0554		17. INFORMANT HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 4700 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLOEROTIC HEART DISEASE DUE TO (c) 5 YRS.				INTERVAL BETWEEN ONSET AND DEATH 36 HRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA - 1 WK.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from FEB. 23 , 1960, to FEB. 24 , 1960, that (I) (we) last saw the deceased alive on FEB. 24 , 1960, and that death occurred 10:15A from the causes and on the date stated above.							
22a. SIGNATURE <i>C. S. Whitaker, M.D.</i>				22b. DATE SIGNED FEB. 25, 1960		22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.	
22d. ADDRESS CLARKSVILLE, MARYLAND				22e. DATE FEB. 25, 1960			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 27, 1960		23c. NAME OF CEMETERY OR CREMATORY Simpson Methodist		23d. LOCATION (City, town, or county) (State) Poplar Springs, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Moleworth</i>				24a. ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	
24c. DATE FEB 29 '60				24d. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 filed 2-23-60 et

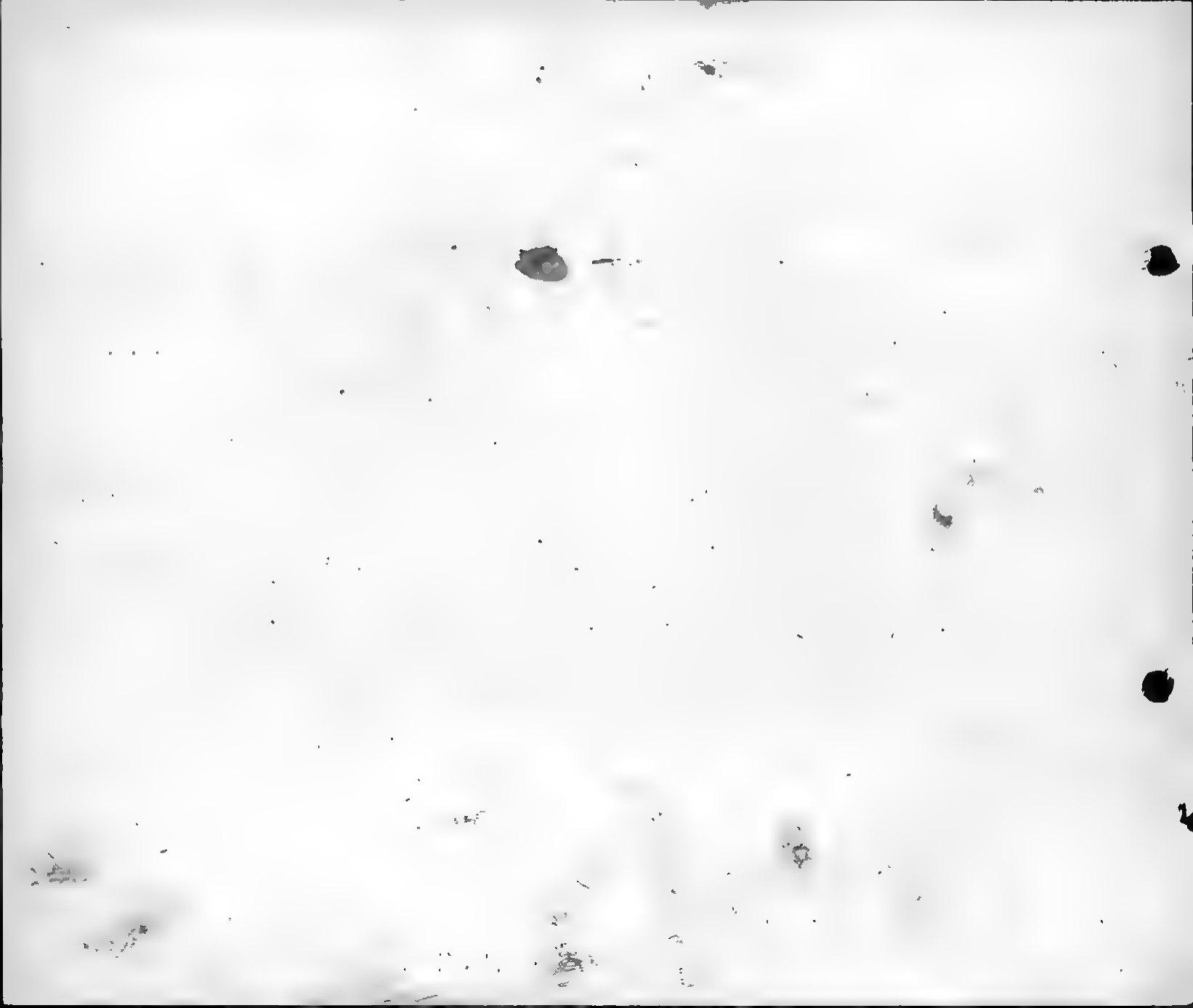
CERTIFICATE OF DEATH

Reg. Dist. No.

2254

02220

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>83X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>2125 Leewood Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>A.</u> Last <u>Nebel</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/26/24 1923</u>	
9. AGE (In years last birthday) <u>36</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wirpel</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sanders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Husband</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compressive pulmonary atelectasis</u> <u>578X</u> DUE TO (b) <u>Serous effusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Immunization and hypoproteinemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulcerative colitis; Status postoperative resection proctocolon</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>FEB 14</u> , 19 <u>60</u> , to <u>FEB 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 22</u> , 19 <u>60</u> , and that death occurred at <u>12:58 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Murphy</u> M.D.				ADDRESS (Street, city or town, state) <u>1801 EYE St NW Washington, DC</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John Murphy</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brown</u>		22d. LOCATION (City, town, or county) (State) <u>Colesburg, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Leroy Mountcastle</u> ADDRESS <u>Cunningham Funeral Home, Inc. Cameron and Alfred Sts. Alex. Va.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



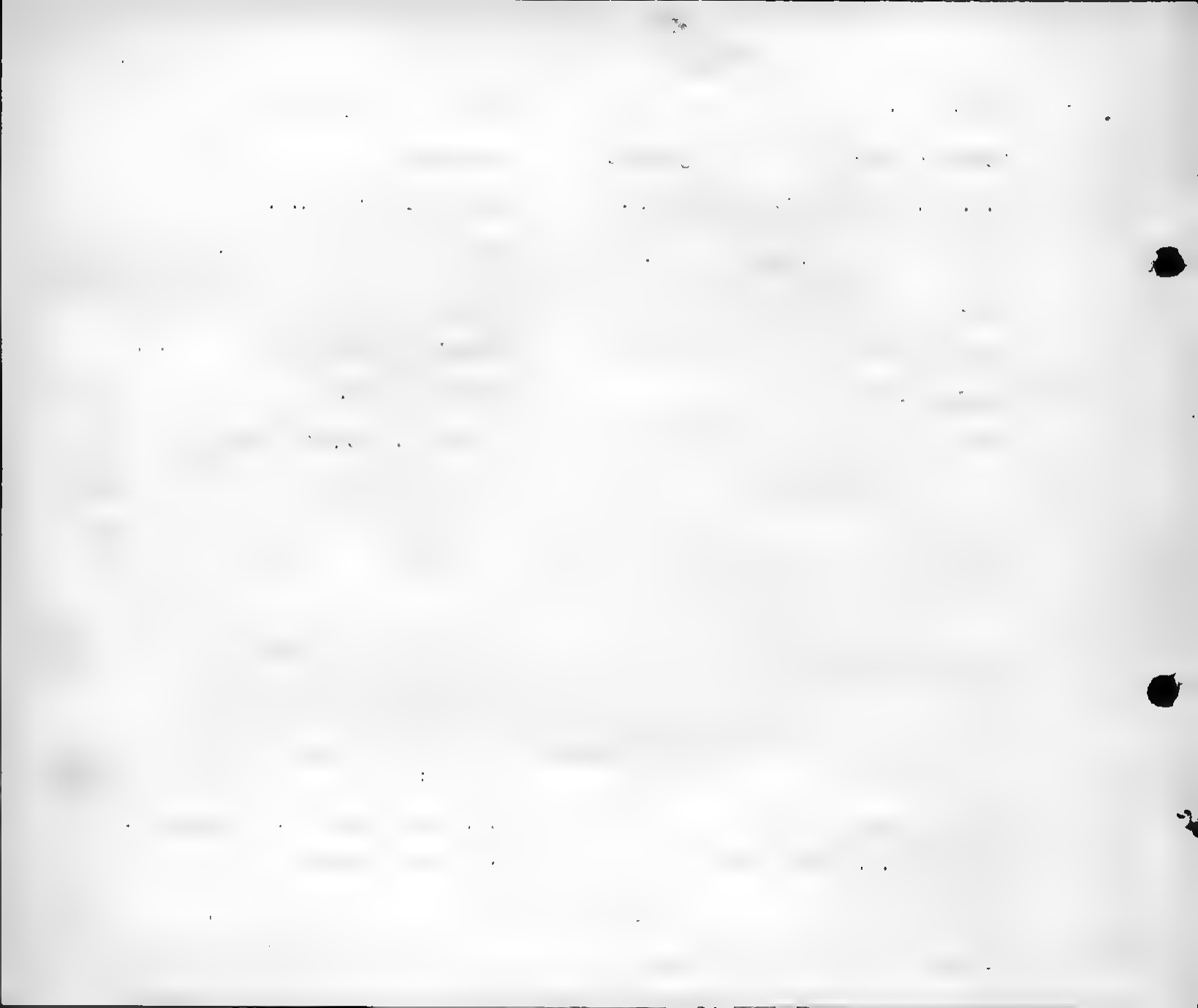
2255 CERTIFICATE OF DEATH

Reg Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia b. COUNTY Y	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X	
f. STREET ADDRESS 2325 42nd Street N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle G. Last NICHOLS		4. DATE OF DEATH Month February Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-93
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George NICHOLS		14. MOTHER'S MAIDEN NAME Frances GAITHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 579-09-6653	
17. INFORMANT (Son) Eugene C. NICHOLS		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 1 month years		INTERVAL BETWEEN ONSET AND DEATH 1 month years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 January , 19 60 , to 27 February , 19 60 , that I last saw the deceased alive on 27 February , 19 60 , and that death occurred at 10:00AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 2-29-60			
ACTUAL SIGNATURE James M. Young		U.S. Naval Hospital, Bethesda Md.	
PHYSICIAN'S NAME (Type) J.M. YOUNG LT MC USN		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Gartner Gaithersburg, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAR 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02222

2256

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 64 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Florida b. COUNTY Orlando		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 X		d. STREET ADDRESS 1101 Nottingham Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		3. NAME OF DECEASED (Type or print) First Minerva Middle (None) Last Nirenberg		4. DATE OF DEATH Month February Day 15 Year 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1905		9. AGE (In years last birthday) 54 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Bykowsky		14. MOTHER'S MAIDEN NAME Lena Raphaelson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 195.0 Bacteremia with gram negative rods DUE TO Right pyelonephritis (b) DUE TO Carcinoma of adrenal cortex with extensive metastasis (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH hours days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from December 13, 1959 to February 15, 1960 , that I last saw the deceased alive on February 15, 1960 , and that death occurred at 12:15A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 2-15-60									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/17/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) Suitland, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krasel							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

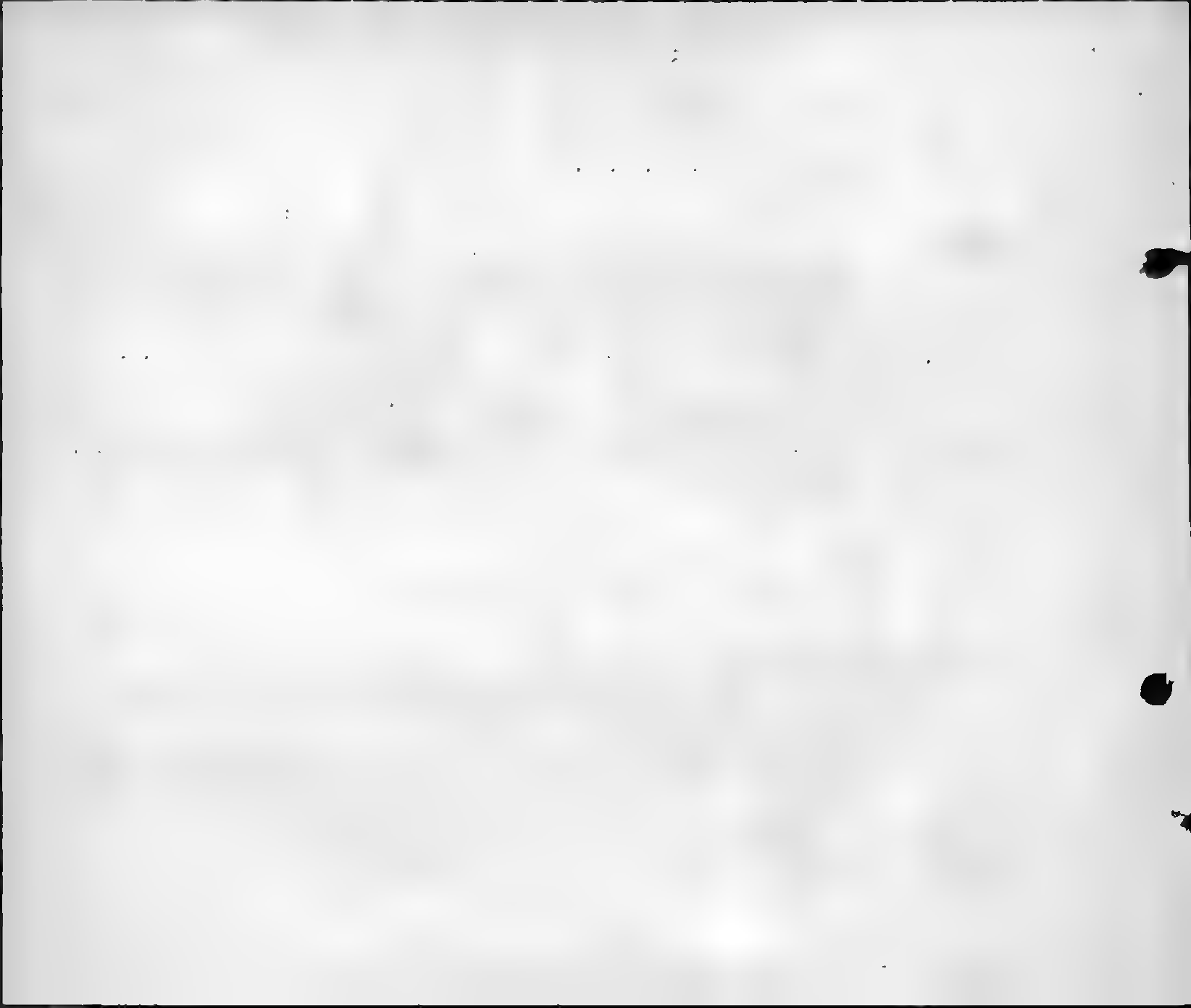
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery 2257 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ken sington		d. STREET ADDRESS 3817 Decatur Ave;	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daisy Middle Nycinth Last Norris				4. DATE OF DEATH Month February Day 14 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900		9. AGE (in years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 1 Days 05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwfr.		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) U: S. A.		12. CITIZEN OF WHAT COUNTRY? U: S. A.	
13. FATHER'S NAME Frank Crist				14. MOTHER'S MAIDEN NAME Lily B. Witt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Della Fram (daughter) 930 Emerson, Wash; D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschant M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschant				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2-14-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/60		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR EB 16 '60		24b. REGISTRAR'S SIGNATURE Carlton J. House	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 8 Film 0257 2-29-60									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7137 Maple Ave					d. STREET ADDRESS 7137 Maple Ave				
3. NAME OF DECEASED (Type or print) Axel A. Ostrom					4. DATE OF DEATH Feb. 23, 1960				
5. SEX male					6. COLOR OR RACE white				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 6/20/1887				
9. AGE (In years last birthday) 72					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Arvid Ostrom					14. MOTHER'S MAIDEN NAME Engman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT Greta S. Ostrom					Address Item 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion									
420.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart									
EXAMINER'S NAME (Type) Frank J. Broschart									
22a. BURIAL, CREMATION, REMOVAL (Specify)									
22b. DATE THEREOF FEB. 25, 1960									
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery									
22d. LOCATION (City, town, or country) (State) Prince Georges County, Md.									
23. FUNERAL DIRECTOR'S ADDRESS 254 Carroll St. N.W. Wash D.C.									
24. REC'D BY REG. STRAR FEB 25 '60									
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna									



2258 CERTIFICATE OF DEATH

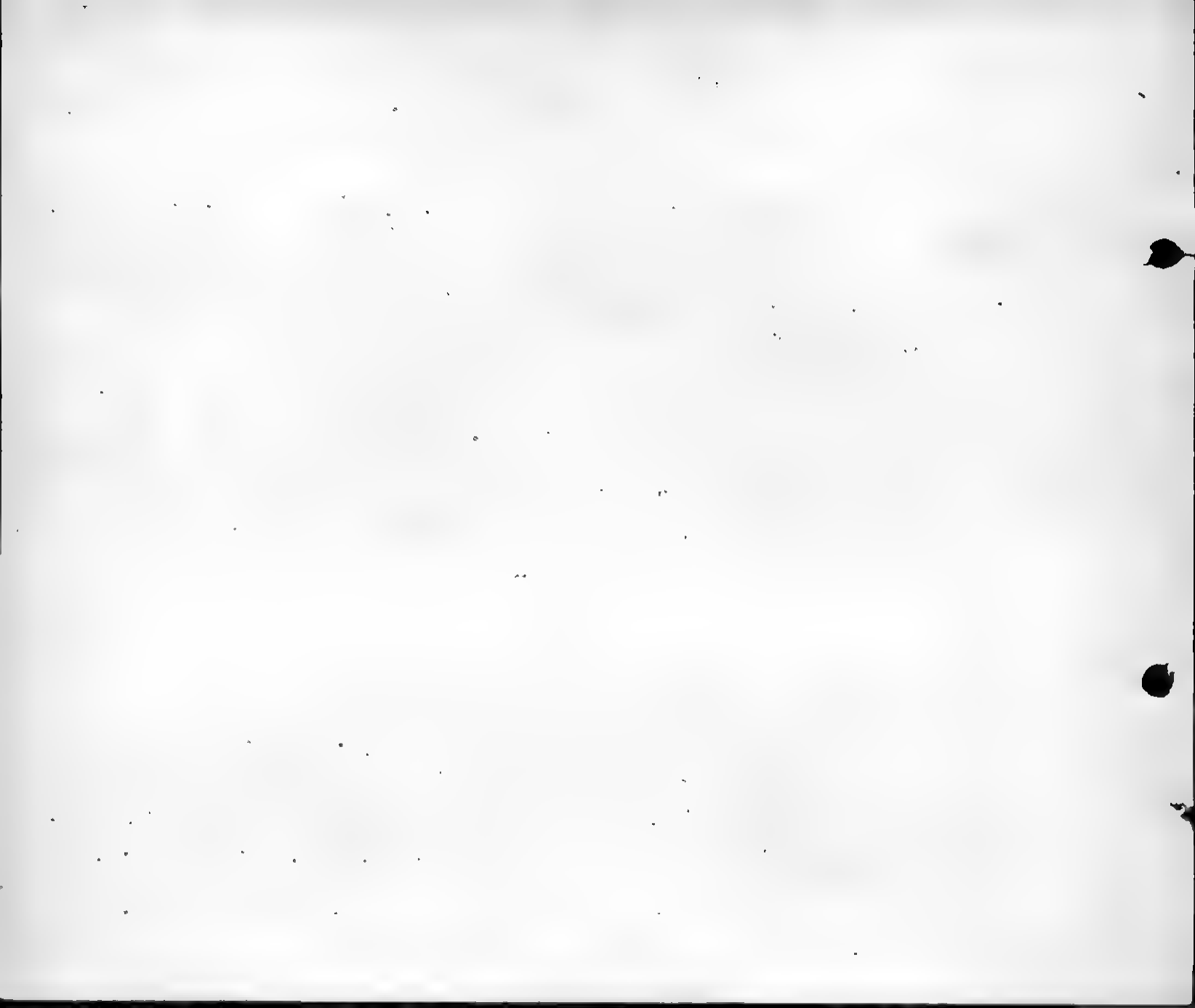
02225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7613-Cayuga Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna M. Pachuta</u>				4. DATE OF DEATH Month Day Year <u>Feb 14 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 4 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Paul Mariniak</u>				14. MOTHER'S MAIDEN NAME <u>Anna Welling for</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Anna Pachuta - daughter</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u>							<u>4 DAYS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							<u>1 MONTH</u>
(c) <u>CEREBRAL THROMBOSIS AND HEMIPLEGIA, RT.</u>							<u>4 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1959</u> to <u>FEB. 14, 1960</u> that I last saw the deceased alive on <u>FEB. 14, 1960</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Leo M. Curtis</u> M.D.				8218 WISCONSIN AVE, BETHESDA, MD. 20814			
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>				8218 Wisc. Ave. Bethesda, Md.			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Mt. Carmel, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02226
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Disf. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sanitarium & Hotel</u>					d. STREET ADDRESS <u>737 Aspen St. N.W.</u>					
3. NAME OF DECEASED (Type or print) <u>Grace Gladmon Pearce</u>					4. DATE OF DEATH Month <u>Feb</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1875</u>		9. AGE (In years last birthday) <u>84</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bureau of Vital Statistics (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>				
13. FATHER'S NAME <u>Burgess K. Gladmon</u>					14. MOTHER'S MAIDEN NAME <u>Elyse E. Duling</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hof record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Broken - femur</u> DUE TO (c) <u>Fracture left hip</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 day</u> <u>3 day</u> <u>10 days</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell off chair to floor at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:30 a.m.</u> <u>2-3-60</u> 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Washington</u> <u>DC</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-13-60</u>					
22a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>			22b. DATE THEREOF <u>2/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines & Co</u>					ADDRESS <u>2901-14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

02227

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2259		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BROOKEVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. RT. #1 Box #159				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET ELLEN PEARCE		4. DATE OF DEATH Month Day Year FEBRUARY 1 19 60					
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/83	9 AGE (In years last birthday) 77 1/2 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WESTLYN DAVIS				14. MOTHER'S MAIDEN NAME JOSEPHINE ROBERTS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NONE		INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured heart 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO (c) Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 2/1 1960 , that I last saw the deceased alive on 2/1 1960 , and that death occurred at 4:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND DATE SIGNED 2/1/60							
ACTUAL SIGNATURE C. H. LIGON		M.D. SANDY SPRING, MARYLAND					
PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-60-		22c. NAME OF CEMETERY OR CREMATORY Salem Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Brookeville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis L. Barber Laytonville Md.				24a. REC'D BY REGISTRAR DATE FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2260 CERTIFICATE OF DEATH

Reg. Dist. No.

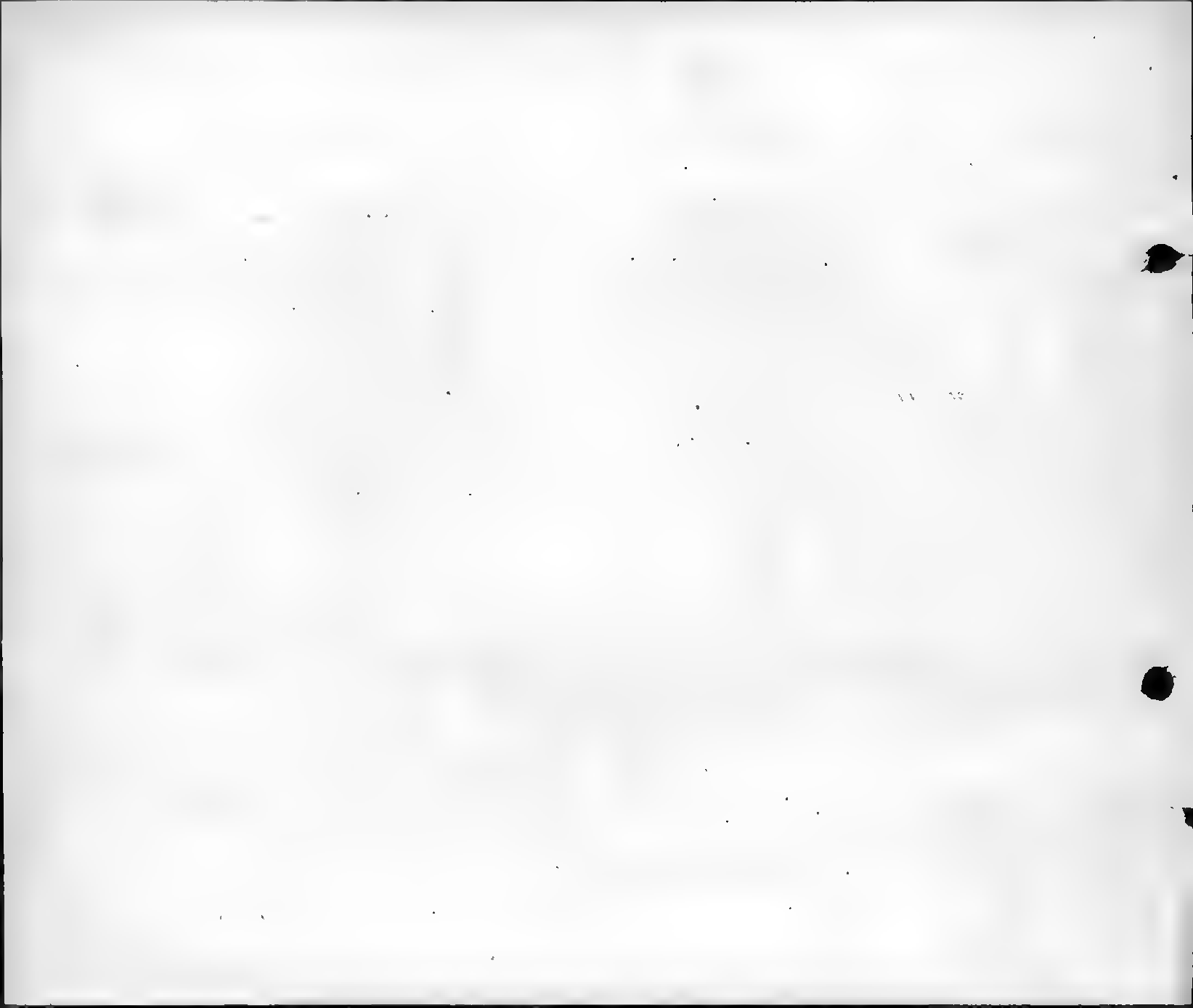
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>V. T.</u> Last <u>Peters</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1917</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John William Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Dare</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>Feb 1, 1960</u> , that I last saw the deceased alive on <u>JAN 27, 1960</u> , and that death occurred at <u>5:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Delwitt E. DeLaucke</u>		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD. Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLaucke, M.D.</u>		DATE SIGNED <u>2/1/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-4-60</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

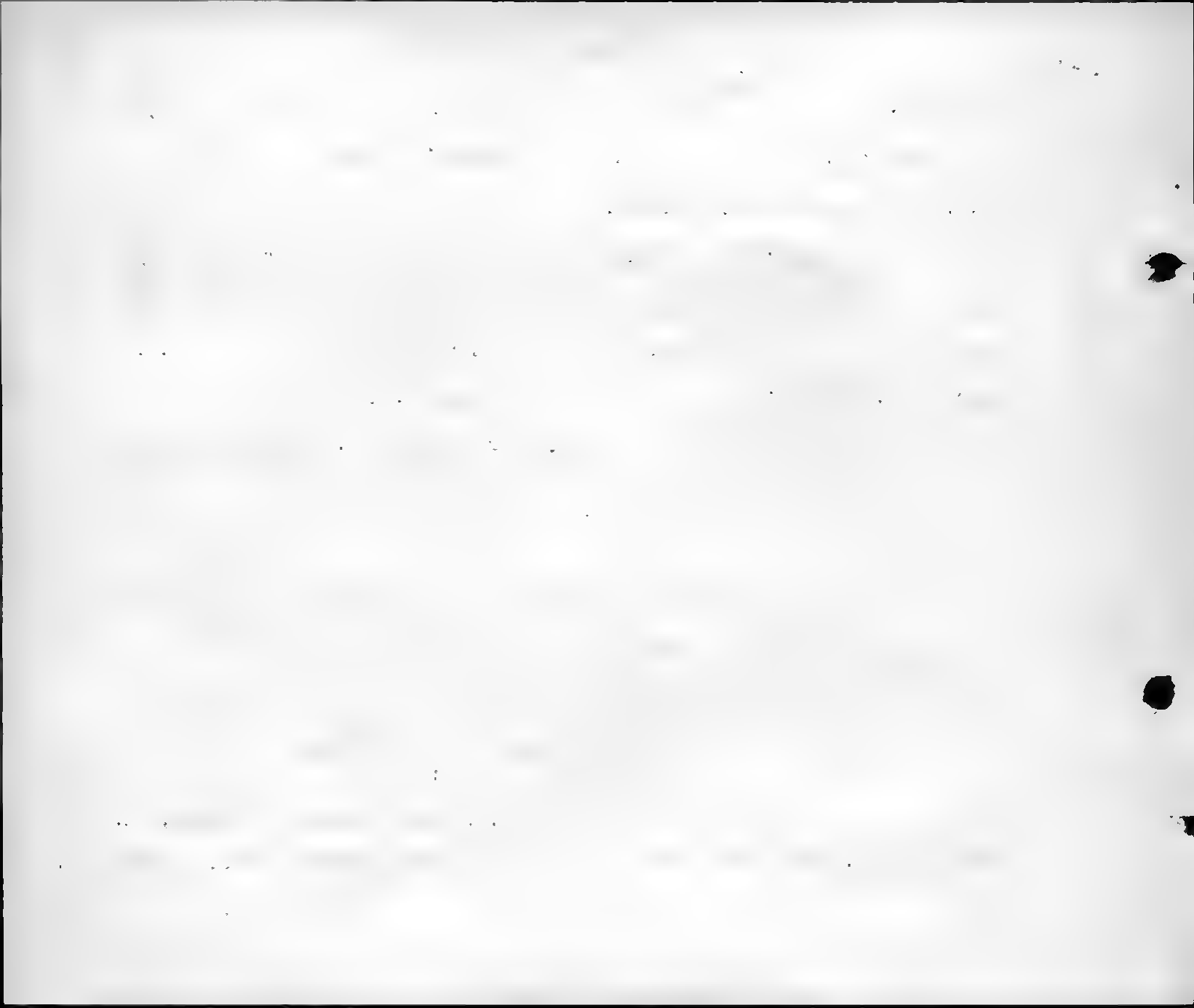
Item 2b Form 10-27-5-2-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02229

1. PLACE OF DEATH a. COUNTY Montgomery 2261 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 hour d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission on) a. STATE Maryland b. COUNTY 2261 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Manor d. STREET ADDRESS 22 Edgewood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roger Middle Gordon Last POCHUREK		4. DATE OF DEATH Month February Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-60
9. AGE (In years last birthday) 22		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lawrence M. POCHUREK		14. MOTHER'S MAIDEN NAME Shirley J. KAPPEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Lawrence M. Pochurek		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apneic spell 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Brain damage DUE TO (c) Hydroanencephaly		INTERVAL BETWEEN ONSET AND DEATH minutes 4 wks 4 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 February, 19 60 to 29 February, 19 60 , that I last saw the deceased alive on 29 February, 19 60 , and that death occurred at 1:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED ACTUAL SIGNATURE G.B. Avery M.D. PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR MAR 3 '60 DATE	
24b. REGISTRAR'S SIGNATURE 2051314XUS			



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

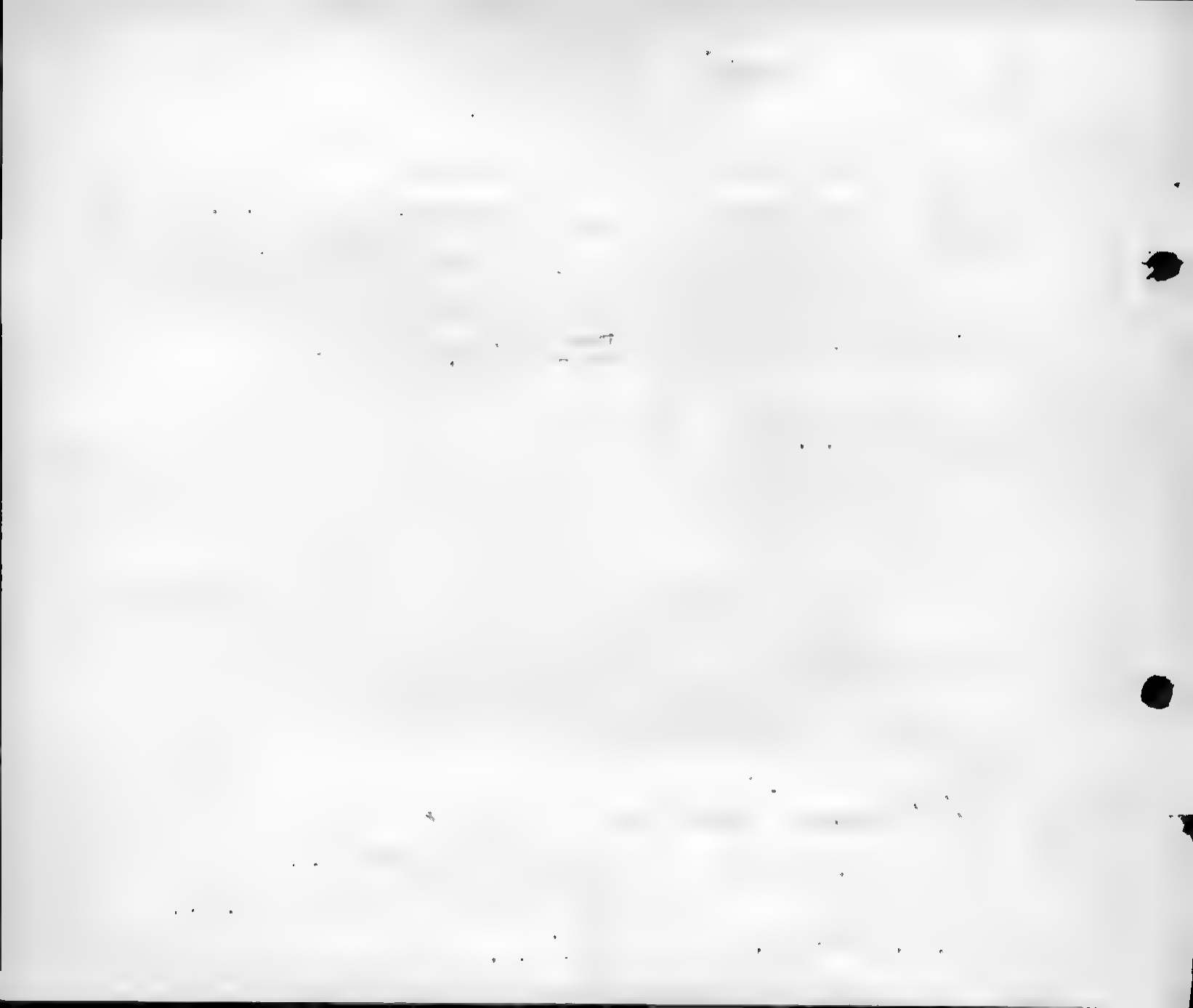
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2262

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02230

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE WASHINGTON, D. C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				d. STREET ADDRESS 6688 32ND PLACE, N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JESSE ELLIS PORTER				4. DATE OF DEATH Month Day Year FEBRUARY 24 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/95	
9. AGE (in years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chief of Domestic Parts Corp. of Engineers-UsGovt.				11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ELLIS PORTER				14. MOTHER'S MAIDEN NAME ANNIE SHERWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. I				16. SOCIAL SECURITY NO no			
17. INFORMANT HOSPITAL RECORDS				Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 9 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEBRUARY 15 19 60 , to FEBRUARY 24 19 60 , that (I) (we) last saw the deceased alive on FEB. 23 19 60 , and that death occurred at 8:10 A.M. , from the causes and on the date stated above							
22a. SIGNATURE William C. Miller M.D.				22b. ADDRESS GAITHERSBURG, M.D.			
22c. PHYSICIAN'S NAME (Type) WILLIAM C. MILLER, M. D.				22d. ADDRESS GAITHERSBURG, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.-2901 14th St., N.W.				25a. REC'D BY REGISTRAR DATE FEB 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

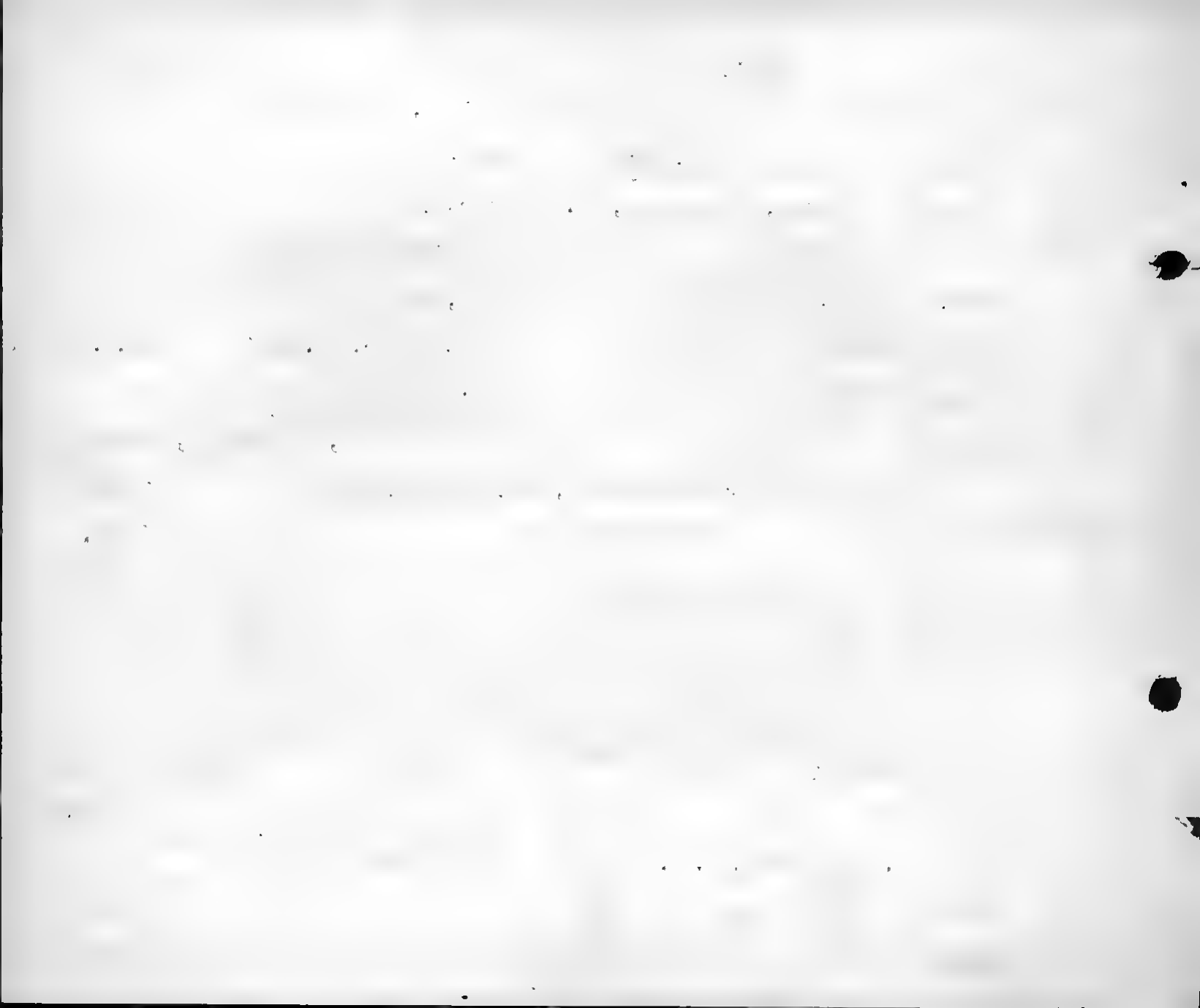


2263
CERTIFICATE OF DEATH

Reg. Dist. No.

02231

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Peru, South America b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Arica 132	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bella Middle Tuchia Last Prentice		4. DATE OF DEATH Month February Day 25 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1953
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Lima, Peru, So. America		12. CITIZEN OF WHAT COUNTRY? Peru, S. America	
13. FATHER'S NAME Carlos Prentice		14. MOTHER'S MAIDEN NAME Bella Tuchia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac failure, postoperative state 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tetralogy of fallot DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 6 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 11, 19 60 , to February 25, 19 60 , that I last saw the deceased alive on February 25, 19 60 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED 2/26/60			
ACTUAL SIGNATURE E. KENT CARNEY, M. D.		M.D. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) E. KENT CARNEY, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP		22b. DATE THEREOF 3-13-1960	
22c. NAME OF CEMETERY OR CREMATORY 1400 Chapin St. N.E. Washington, D.C.		22d. LOCATION (City, town, or county) (State) IGUITOS PERU SO AMERICA	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers G		24a. REC'D BY REGISTRAR MAR 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

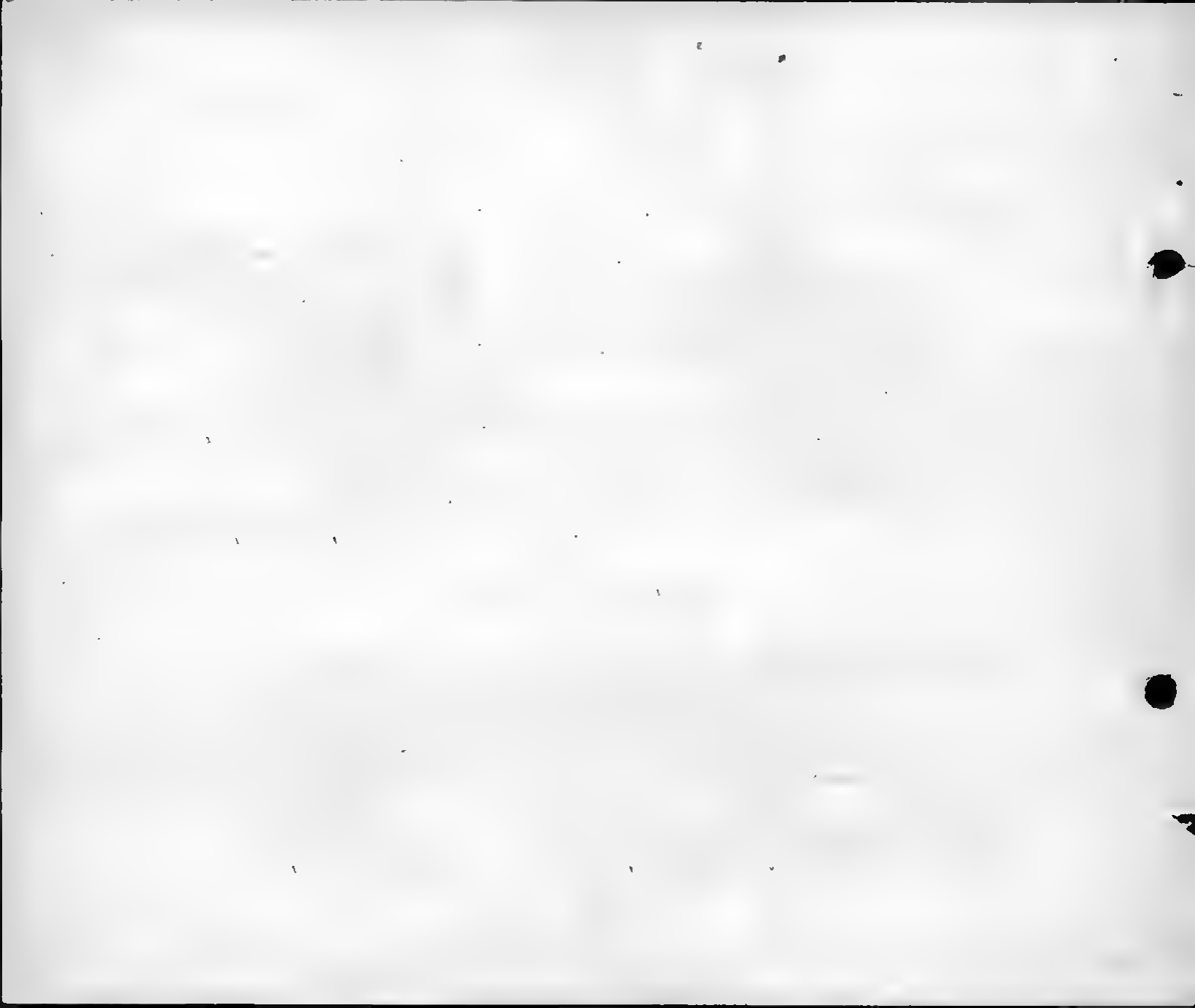
Reg. Dist. No.

02232

2264

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				/d. STREET ADDRESS Box 113		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Buearl Last Puckett				4. DATE OF DEATH Month February Day 6 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1910	
9. AGE (In years last birthday) 49 yrs		F UNDER 1 YEAR? Months 49 Days 49 Hours 49 Min 49		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Montg. Co. Tree		11. BIRTHPLACE (State or foreign country) Div. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sam Joseph Puckett				14. MOTHER'S MAIDEN NAME Taves May Stevebsib			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11 230-14-289			
17. INFORMANT Mildred B. Puckett				Address Box 113, Brookeville Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Right Lung 162.1 DUE TO with metastases to left lung, liver, lymph Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) nodes, and vertebrae DUE TO (c) six mos.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from October 18 59 to Feb. 7 19 60 , that I last saw the deceased alive on February 6 19 60 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED Charles S. Whitaker, M.D.							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.							
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				ADDRESS 1331 E. Montg. Rockville, Md.		24a. REC'D BY REGISTRAR AYB 9 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2265 CERTIFICATE OF DEATH

Reg. Dist. No.

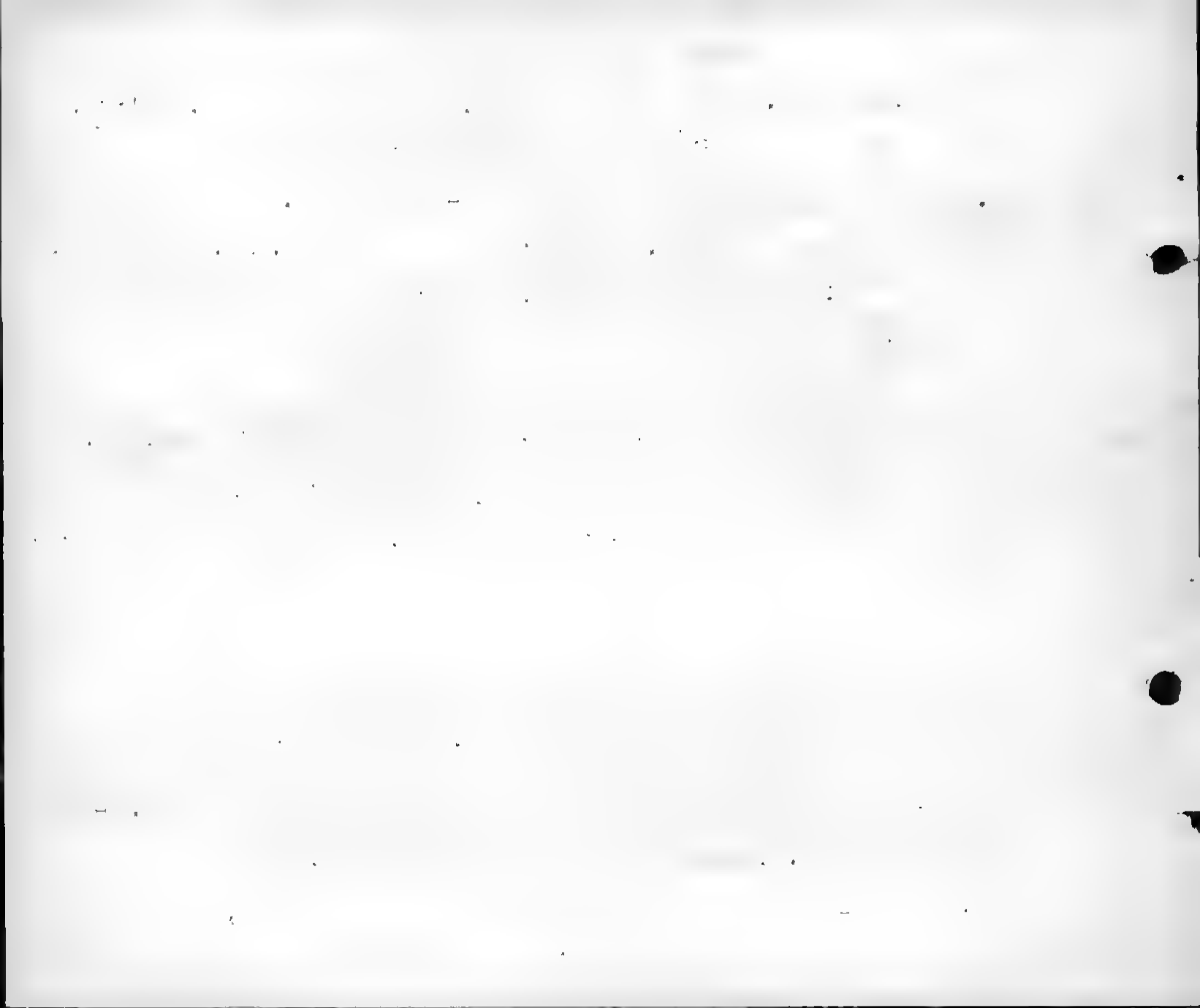
1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland b. COUNTY Pr. Geo's Co. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b District Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomema Nursing Home		d. STREET ADDRESS 7609 - Gateway Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES First B. Middle PUMPHREY Last		4. DATE OF DEATH Feb. 8th. Month Feb. Day 8th. Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24th 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mollie Soper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO No	
17. INFORMANT Mrs. Marian Ellis		Address 7609--Gateway Blvd, District Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Generalized Arteriosclerosis Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) 20 years		INTERVA. BETWEEN ONSET AND DEATH one week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 6, 1960 to February 8, 1960 , that I last saw the deceased alive on Feb 8, 1960 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE HARRY J. KIOHERER M.D.		ADDRESS (Street, city or town, state) 5527 Surrey St, Chevy Chase, Md.	
PHYSICIAN'S NAME (Type) HARRY J. KIOHERER		DATE SIGNED Feb. 8-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town or county) (State) Washington, DC	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros ADDRESS 1661--Good Hope Rd., SE Washington 20 DC		24a. REC'D BY REGISTRAR FEB 10 1960	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02234

1. PLACE OF DEATH a. COUNTY Montgomery 3266 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6912 Barret Ave		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE New Jersey b. COUNTY Verona c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Verona d. STREET ADDRESS 87 Forest Ave <div style="text-align: right;">17-3 • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
3. NAME OF DECEASED (Type or print) AUGUSTA PURLSON		4. DATE OF DEATH Feb 21 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 12 1898
9. AGE (In years (in days) 62 yrs. IF UNDER 1 YEAR 0 Mths 9 yrs IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham Cohen	
14. MOTHER'S MAIDEN NAME Rose Soper		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. No		17. INFORMANT Sanford Slavin Address Itd Id (Son In Law)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-23-60	
22c. NAME OF CEMETERY OR REPOSITORY KING DAVID MEMORIAL GARDEN - FALLS CHURCH. VA.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14 135th NW ADDRESS		24a. REC'D BY REGISTRAR FEB 24 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2267

CERTIFICATE OF DEATH

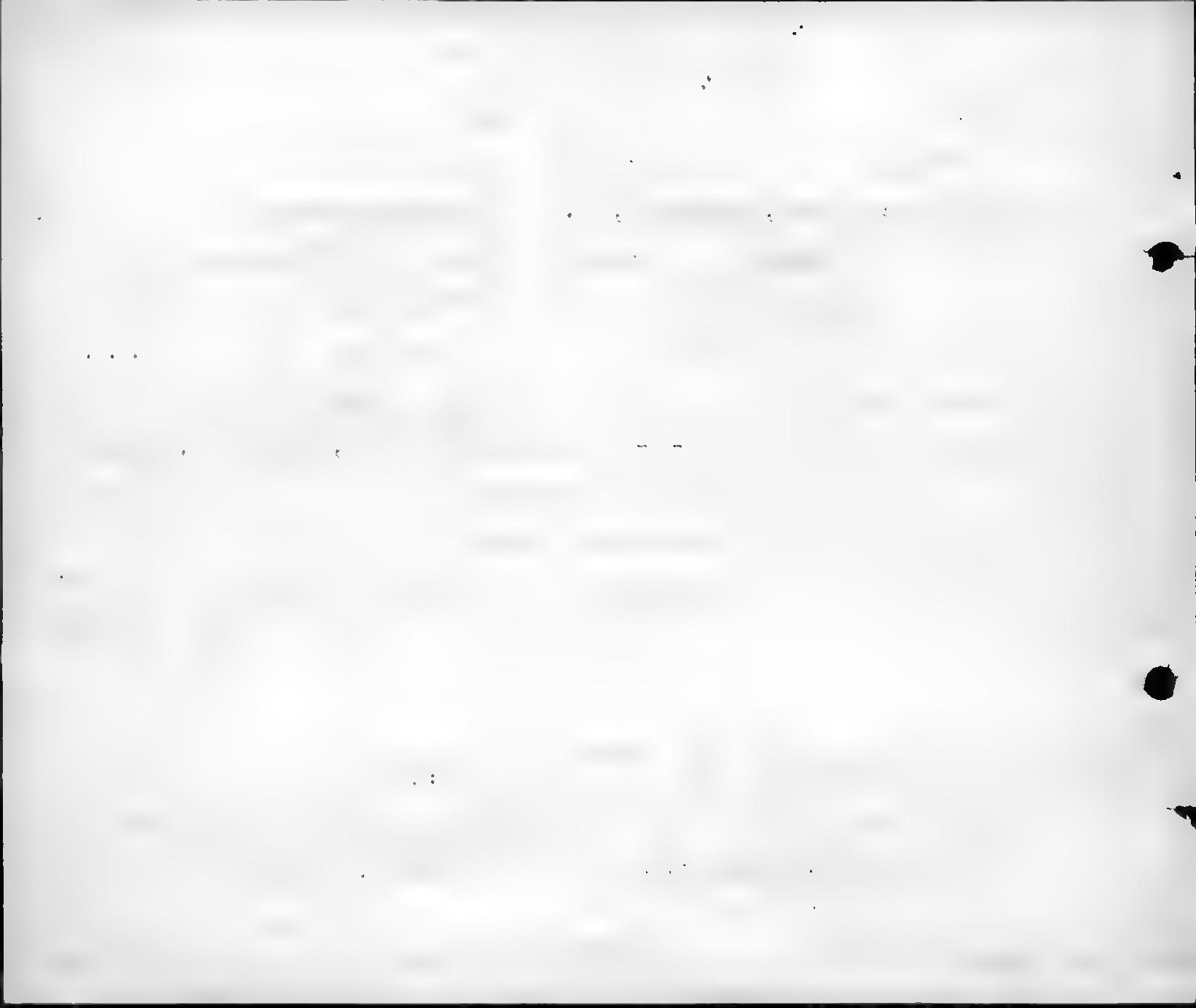
Reg. Dist. No.

02235

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 57 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE New York b. COUNTY New York City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City d. STREET ADDRESS 505 West 161st Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Aristides Last Ramirez		4. DATE OF DEATH Month February Day 16 Year 19 60					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1933	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min 26		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Puerto Rico			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Tomas Ramirez		14. MOTHER'S MAIDEN NAME Theresa Chapriel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 126-24-1076		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Candida parapsilosis DUE TO (c) Endocarditis - aortic valve CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. 401.1 11 months					INTERVAL BETWEEN ONSET AND DEATH 2 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 21, 1959 , to February 16, 1960 , that I last saw the deceased alive on February 16, 1960 , and that death occurred at 6:24 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED February 17, 1960							
ACTUAL SIGNATURE Howard M. Kravetz		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) HOWARD M. KRAVETZ, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		22b. DATE THEREOF 2/18/60		22c. NAME OF CEMETERY OR CREMATORY New York N.Y.			
22d. LOCATION (City, town, or county) (State) New York N.Y.		23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		24a. REC'D BY REGISTRAR DATE FEB 19 1960			
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

3
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2268

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton Silver Spring
c. LENGTH OF STAY IN 1b 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2620 Blue Ridge Ave

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Montg
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 56 Wheaton Silver Spring
d. STREET ADDRESS 2620 Blue Ridge Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Dorsey Lee Reynolds
4. DATE OF DEATH Feb 18 1960
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 6-24-1883 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months 7 Days 18 IF UNDER 24 HRS.: Hours 1 Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman - Montg. Co. Highway Dept. 10b. KIND OF BUSINESS OR INDUSTRY Va 11. BIRTHPLACE (State or foreign country) Va 12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME JOSEPH Reynolds 14. MOTHER'S MAIDEN NAME ELIZABETH THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give years or dates of service) NO 16. SOCIAL SECURITY NO. 213-40-8022 17. INFORMANT Cornelia Reynolds (wife) Address Stun 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden
DUE TO (c) sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

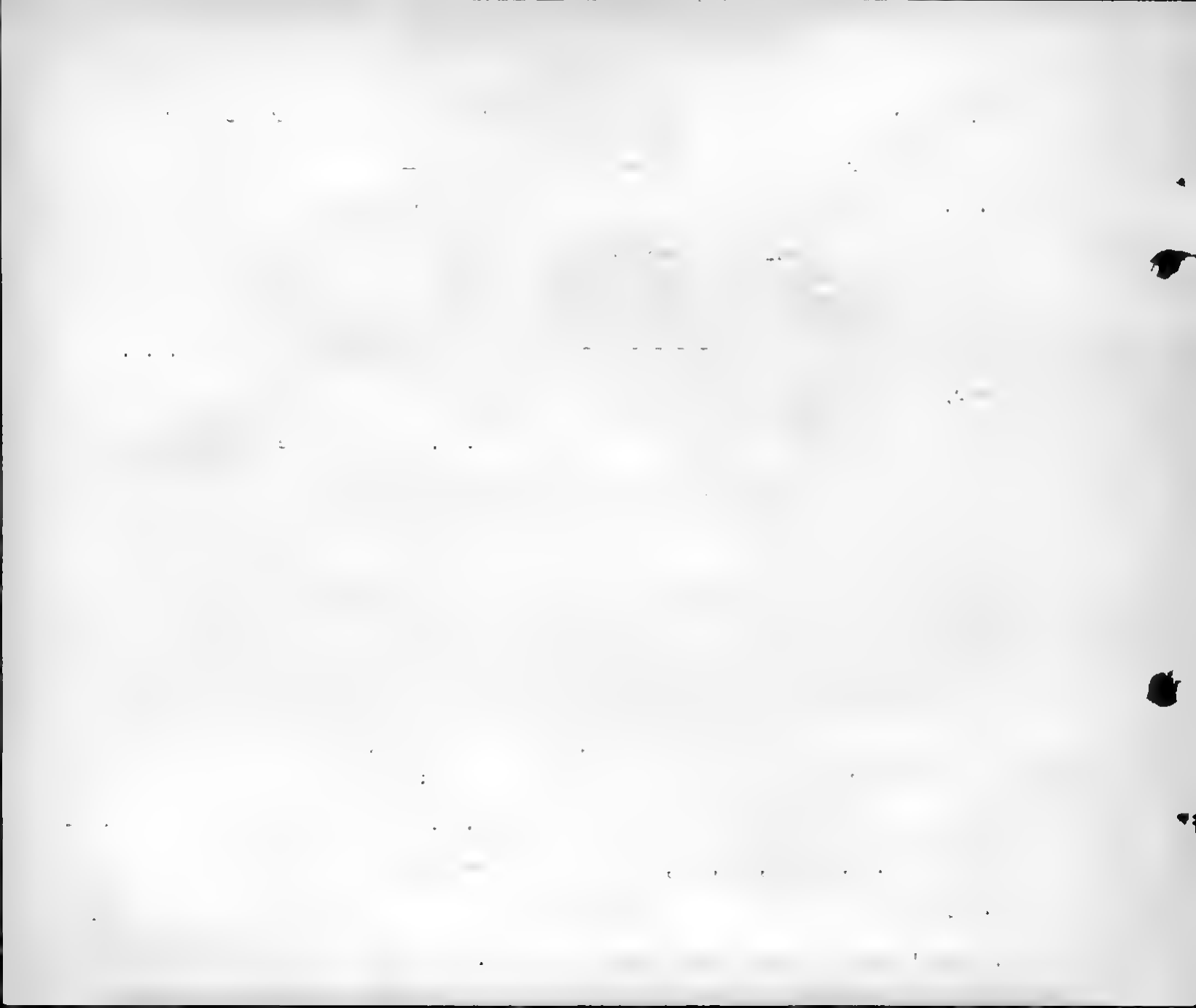
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 2-18-60

ACTUAL SIGNATURE Frank J. Brosenart M.D. EXAMINER'S NAME (Type) FRANK J. Brosenart Address (Street, city, town, or county) 2-18-60

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2/23/60 22c. NAME OF CEMETERY OR CREMATORY IVY HILL CEMETERY 22d. LOCATION (City, town, or country) (State) ALEXANDRIA, VIRGINIA

23. FUNERAL DIRECTOR WALTER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR Raymond A. Ziska DATE FEB 23 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Howard

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No

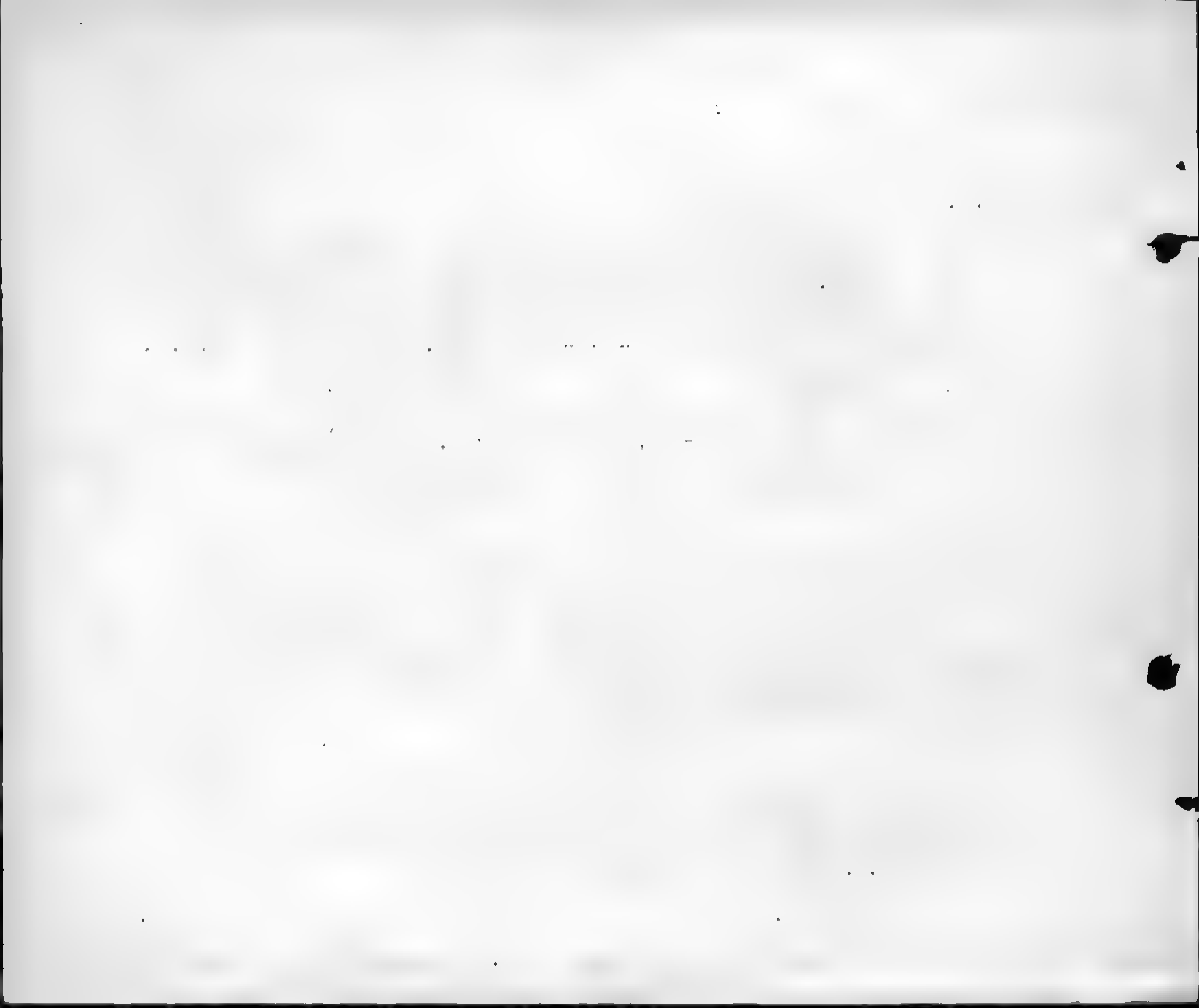
02258
215

2270

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. NAVAL HOSPITAL NMMC		e. STREET ADDRESS 3135 Martha Custis Drive	
3. NAME OF DECEASED (Type or print) Audrey First Weston Middle RICH Last		4. DATE OF DEATH February Month 6 Day 60 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-83
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George RHINES		14. MOTHER'S MAIDEN NAME Effie RHINES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 021-05-7486	
17. INFORMANT Elinor D. RICH(D)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 31 January 1960 to 6 February 1960 , that I last saw the deceased alive on 6 February 1960 , and that death occurred at 2015 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Marshall W. Olson M.D.		ADDRESS (Street, city or town, state) U.S.N.H., NMMC, Bethesda 2860	
DATE SIGNED			
PHYSICIAN'S NAME (Type) M.W. OLSON		LCDR MC USN	
22a. BURIAL, CREMATORY, REMOVAL (Specify) Burial	22b. DATE THEREOF 11 Feb. 1960	22c. NAME OF CEMETERY OR CREMATORY Plain Street Cemetery	22d. LOCATION (City, town, or county) (State) Braintree, Mass.
23. FUNERAL DIRECTOR'S SIGNATURE Wheatley Funeral Home		ADDRESS Alexandria, Va.	24a. REC'D BY REGISTRAR FEB 9 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

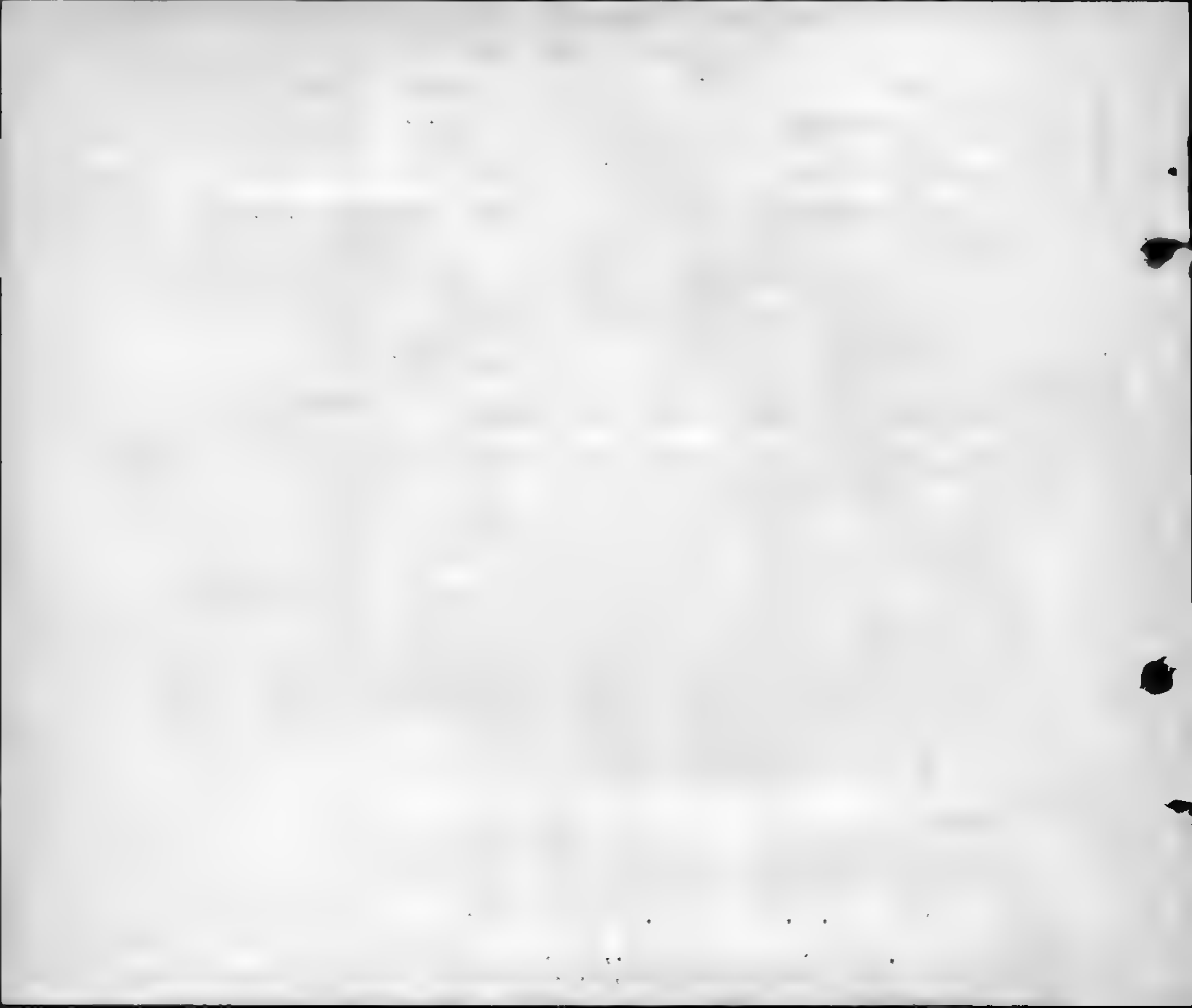
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 20 Film 200 Maryland State Department of Health—BALTIMORE, 18 3-10-60 ams										02239	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					477	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital					d. STREET ADDRESS 1331 Rittenhouse St. N.W.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Chesman Last Ricketts			4. DATE OF DEATH Month February Day 19 Year 1960								
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1910		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) British W. Indies			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Ricketts					14. MOTHER'S MAIDEN NAME Lillian Jeffries						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Estelle Gonzales (Neife) Address RA3-2541			(As above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 936.5 DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of Gastric Contents DUE TO (c) Aspiration of Gastric Contents INTERVAL BETWEEN ONSET AND DEATH 10 min.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Was driving his car & stopped to repair his tire chains when he suddenly collapsed								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:20 p.m. 2-19 1960			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Bethesda		(County) Montg.		(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Nonfatal Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Frank J. Bluschant M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) FRANK J. Bluschant					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 2-19-60						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2.24.60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			22d. LOCATION (City, town, or county) Washington, D.C.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire					ADDRESS 1820 9th St., N.W.			24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE Charles J. H.	
					Washington, D.C.						



2272 CERTIFICATE OF DEATH

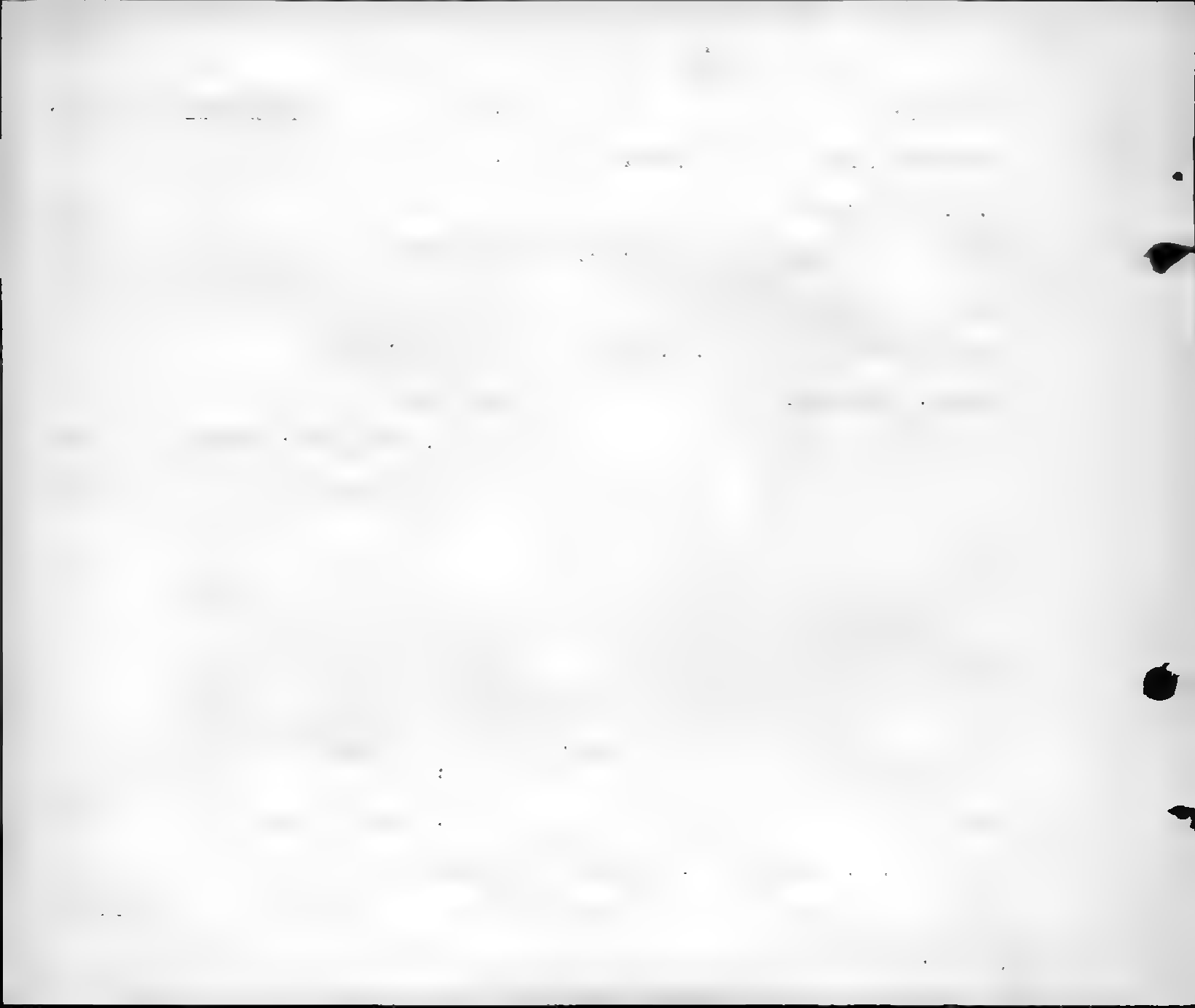
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 101 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolersville		d. STREET ADDRESS 1 - - - - -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Lawrence Last RIHELDAFFER				4. DATE OF DEATH Month February Day 6 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-89	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. RIHELDAFFER				14. MOTHER'S MAIDEN NAME Laura HARDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WWI - WWII		INFORMANT Address (W) Evelyn D. Riheldaffer, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, bronchogenic 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 7 mo	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28 , 19 59 , to February 6 , 19 60 , that I last saw the deceased alive on February 6 , 19 60 , and that death occurred at 8:15P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. J. Linehan		ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2-7-60					
PHYSICIAN'S NAME (Type) F. J. LINEHAN, JR., LCDR, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMAT. OR REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-9-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	
24a. REC'D BY REGISTRAR DATE FEB 9 '60							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

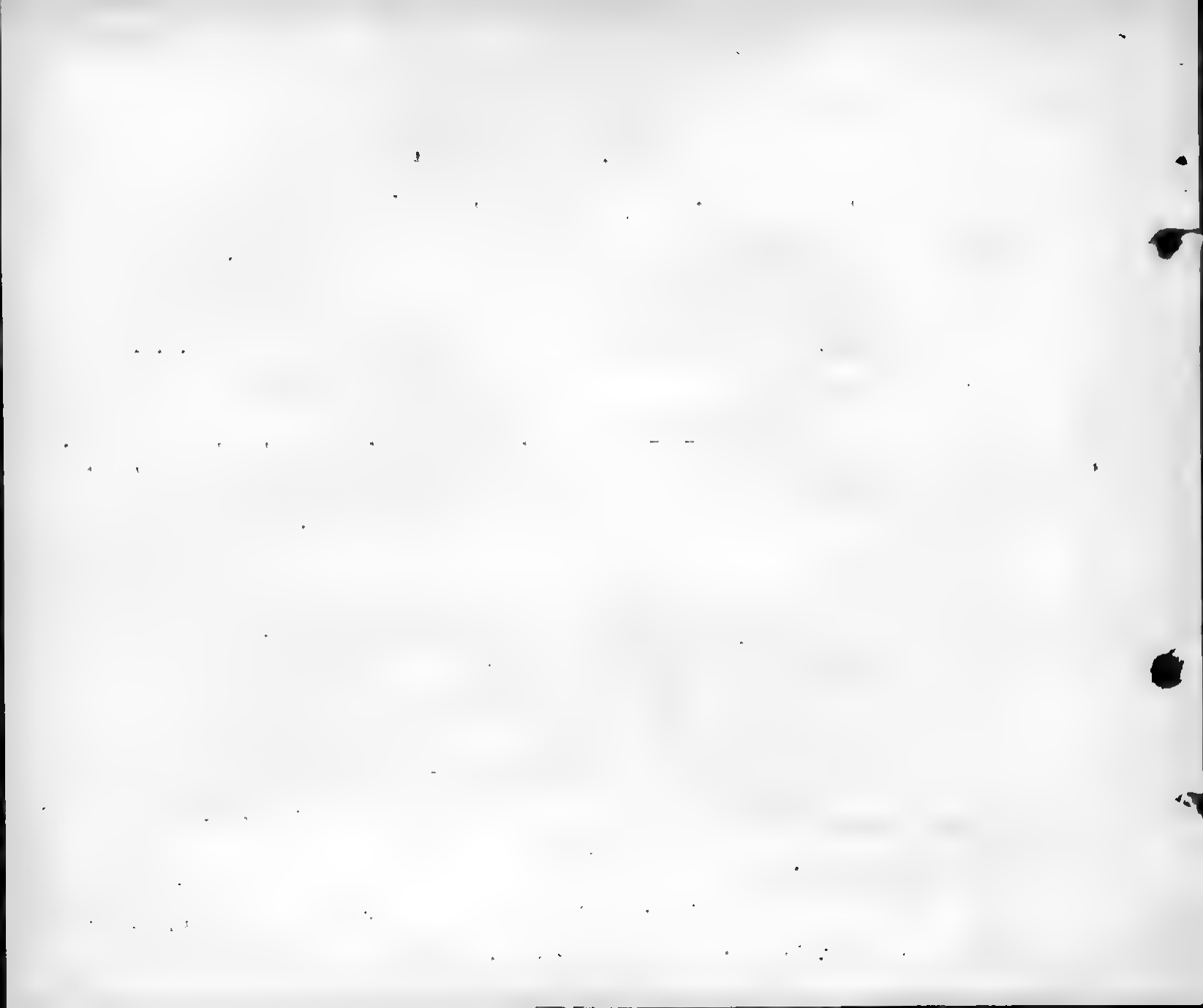
2125

CERTIFICATE OF DEATH

Reg. Dist. No

02241

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		d. STREET ADDRESS 12,715 Flack Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,715 Flack St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle GRANT Last ROBERTS		4. DATE OF DEATH Month FEB. Day 14 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/27/04
9. AGE (In years last birthday) yn. 55		10. IF UNDER 1 YEAR Months 5 Days 14 Hours 19 Min 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dance Instructor		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHEN ROSENBERG		14. MOTHER'S MAIDEN NAME ? SULLIVAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 172-24-2415	
17. INFORMANT Mrs. Catherine W. Roberts, 12,715 Flack St.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Coronary Arteriosclerosis 5 years Acute Myocardial Infarction 1 day		INTERVAL BETWEEN ONSET AND DEATH 5 years 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1958 to Feb 14, 1960 that I last saw the deceased alive on Feb 14, 1960 , and that death occurred at 5 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE John J. Curry M.D.		10620 Georgia Ave 2/14/60	
PHYSICIAN'S NAME (Type) JOHN J. CURRY		Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/17/60	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or County) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR FEB 16 60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



2273 CERTIFICATE OF DEATH

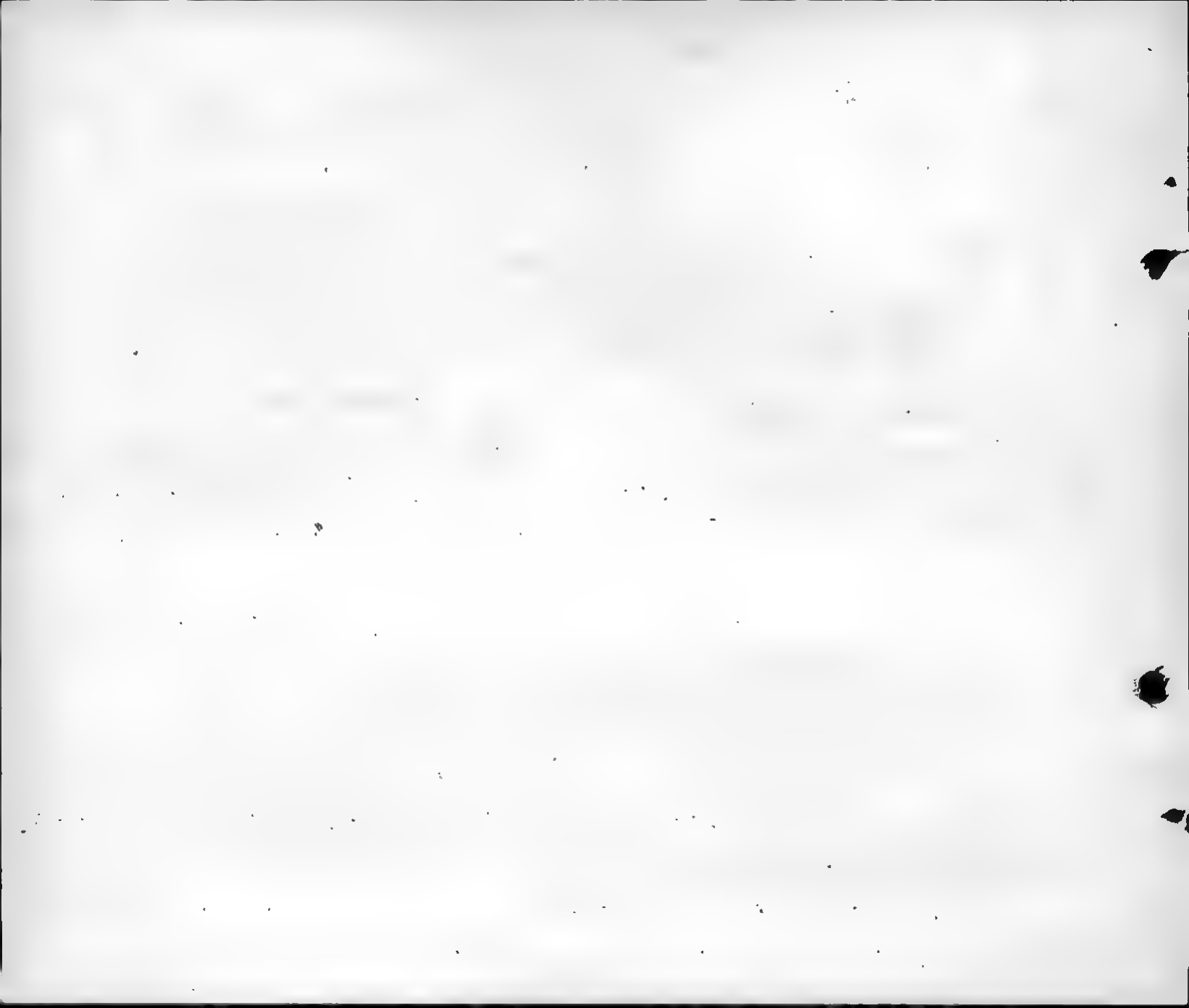
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Ellen Last Robinson		4. DATE OF DEATH Month Feb. Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/77
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min 82	11. IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOMEN'S HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Jackson, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN Henry Strope		14. MOTHER'S MAIDEN NAME CATHERINE FOX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Maurice Robinson (Husband)		Address Same as Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last, (b) Arteriosclerosis-Cerebral Arteriosclerosis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 40 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Complicated by Nephropathy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-3-1960 to 2-5-1960 , that I last saw the deceased alive on 2-5-1960 , and that death occurred at 4:45 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED P. P. Andrews M.D. 4201 Wisconsin Ave. N.W. 2-5-60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Peter P. Andrews			
22a. BURIAL CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 2/8/60	
22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) COLUMBUS, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
24b. REGISTRAR'S SIGNATURE William S. Hanks			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the information required. The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the information required.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2152

CERTIFICATE OF DEATH

02243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>		e. STREET ADDRESS <u>118 HILLTOP RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED JEANNETTE ROSE</u>		4. DATE OF DEATH Month Day Year <u>FEB 14 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>HURLIE R. LONTZ</u>		14. MOTHER'S MAIDEN NAME <u>EFFIE FENIMORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>Abdominal Viscera secondary to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of Colon</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 3 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Feb 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>60</u> , and that death occurred at <u>1:35</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George L. Ball</u> M.D. <u>10620 Georgia Ave Feb 14/1960</u> PHYSICIAN'S NAME (Type) <u>George L. Ball</u> <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hall</u> ADDRESS <u>WASH DC</u>		24a. REC'D BY REGISTRAR <u>2540 Campbell St NW</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>FEB 17 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02244

2274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>DOA</u>				d. STREET ADDRESS <u>9705 De Paul Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christopher A. Ross</u>				4. DATE OF DEATH Month Day Year <u>Feb 19 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11-1960</u>	
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>8</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>William David Ross</u>				14. MOTHER'S MAIDEN NAME <u>Patricia June Bagley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Suburban Hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congestive heart failure</u> DUE TO (b) <u>Subacute stenosis</u> DUE TO (c) <u>Congenital heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

2074215XUS



CERTIFICATE OF DEATH

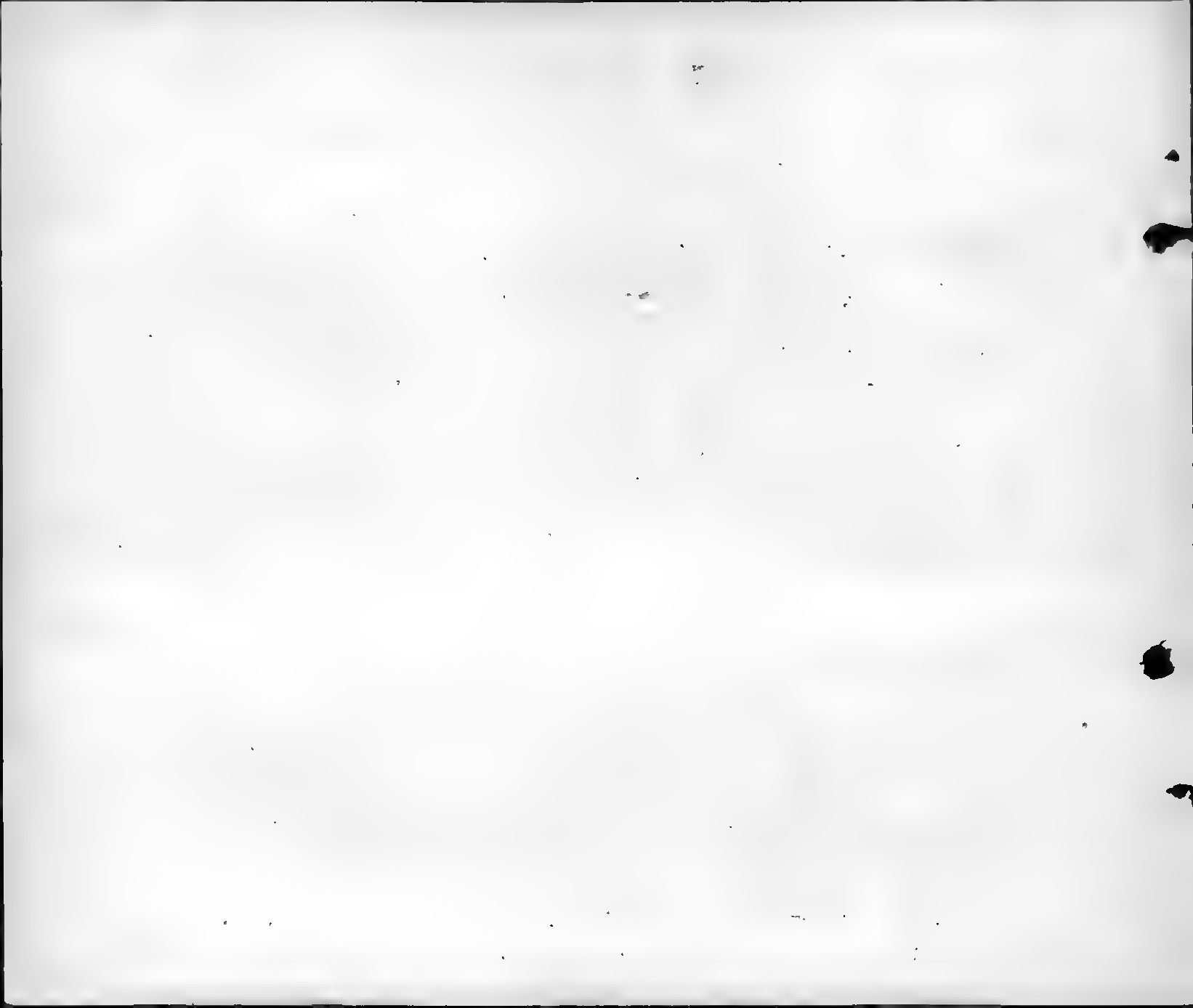
Reg. Dist. No.

2153

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>16 da.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium Hospital</i>		d. STREET ADDRESS <i>415 19th St. N.W.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Fannie Otto Rupert</i>		4. DATE OF DEATH Month Day Year <i>Feb 23 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-70</i>
9. AGE (In years last birthday) <i>29</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired - War Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Rupert, Wm.</i>		14. MOTHER'S MAIDEN NAME <i>Martin, Elizabeth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>-</i>		Address <i>-</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Glomerular Nephritis</i> <i>572x</i> DUE TO (b) <i>Mural Thrombosis aorta</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>-</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>-</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>		20f. (City or town) (County) (State) <i>-</i>	
21. I certify that I attended the deceased from <i>2-9-</i> , 19 <i>60</i> , to <i>2-23</i> , 19 <i>60</i> that I lost saw the deceased alive on <i>2-23</i> , 19 <i>60</i> , and that death occurred at <i>-</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>809 Davis Ave., T. Park, Md.</i> DATE SIGNED <i>2/23/60</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare M.D.</i>		<i>-</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>2-26-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jas. Sawicki</i>		24a. REC'D BY REGISTRAR <i>-</i> DATE <i>FEB 25 '60</i>	
ADDRESS <i>1756 Pa. Ave. N.W.</i>		24b. REGISTRAR'S SIGNATURE <i>Curtis E. Hanna</i>	

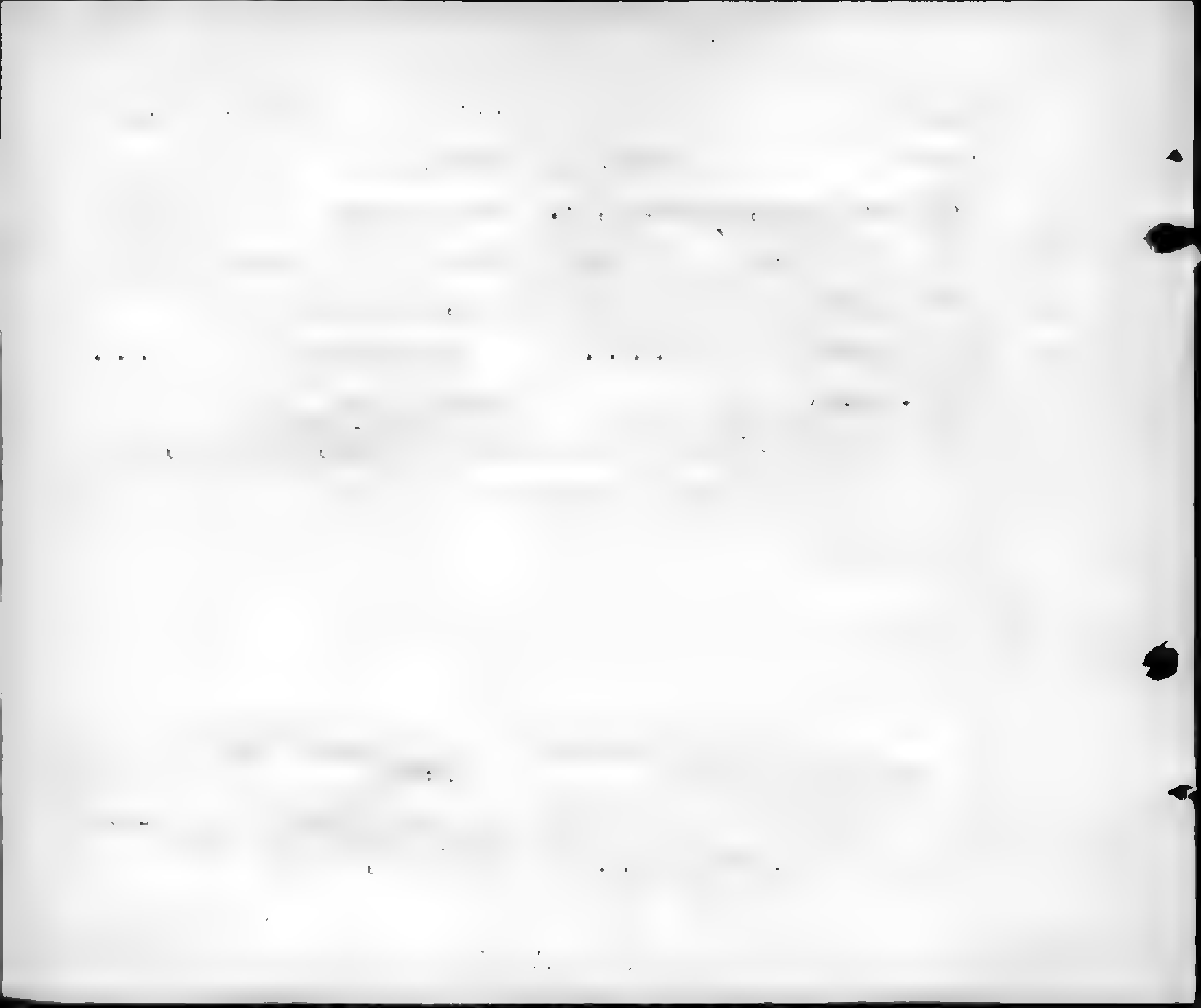
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS A15 (4)
15M 9/SB

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 88 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		16.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 100 3rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Clyde		Middle (None)		Last Russell	
4. DATE OF DEATH		Month February		Day 19		Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1914		9. AGE (In years last birthday) 45 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Staff Sergeant		10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Russell				14. MOTHER'S MAIDEN NAME Hattie Wiseman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (Active duty) Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Obstruction							
19a. 9 DUE TO							
(b) Malignant Melanoma							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF DEATH Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 23, 1959 , to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred at 10:00am from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles E. Mengel M.D.		The Clinical Center 2-19-60					
PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. J. Rinaldi		ADDRESS Rinaldi Funeral Home, Inc. 816 H St., NE, Wash., DC		24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE L. S. Frank	



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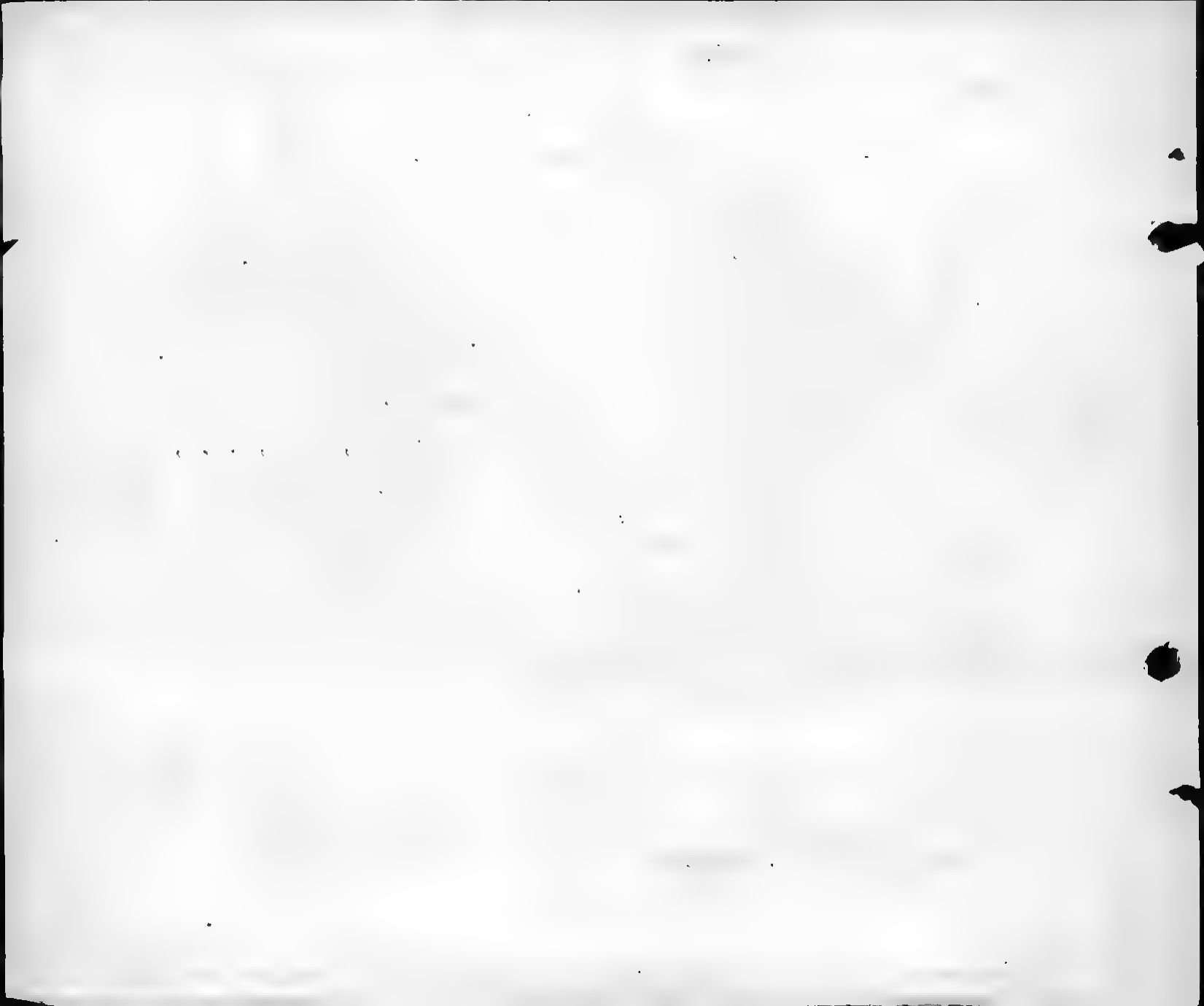
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2154 CERTIFICATE OF DEATH

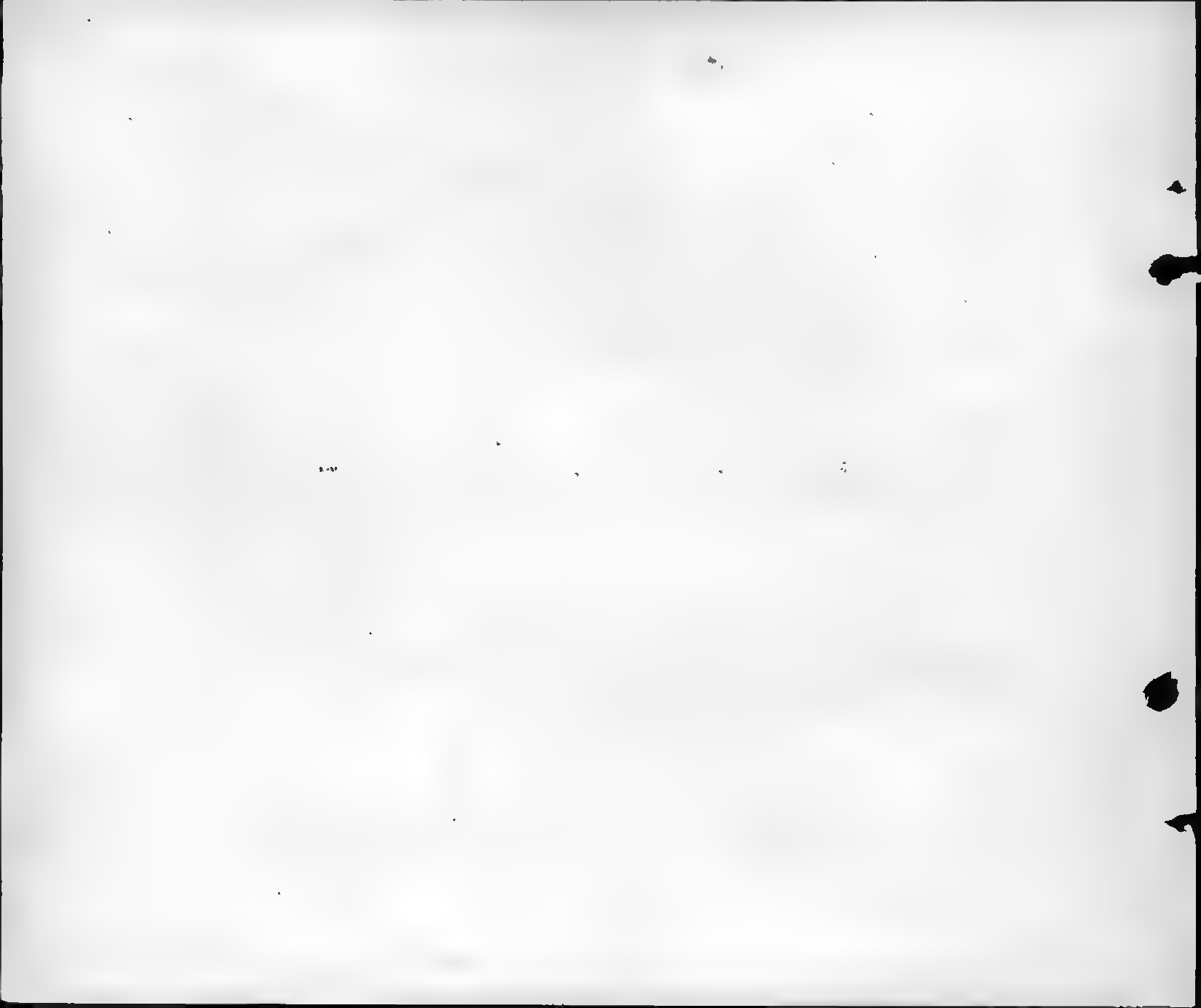
Reg. Dist. No.

02248

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>50 min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4865-66th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>Joseph</u> Last <u>SCHANA</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>60</u> <u>Feb 29 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/80</u>
9. AGE (In years last birthday) <u>79</u> yrs	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	11. IF UNDER 24 HRS Hours <u>1</u> Min <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>American</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>? Duchon</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SON-Jennings W Schana</u>		Address <u>4865-66th Ave Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO <u>Cerebral arterioecclrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(same)</u> DUE TO (c) <u>(same)</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Medical anticoagulation (Dicumeral)</u>			
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1959</u> to <u>2/29/60</u> , that I last saw the deceased alive on <u>Feb. 6, 1960</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring, Md.</u> DATE SIGNED <u>2/29/60</u>			
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D.		PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>	
22a. REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 Lo Ave, N.E.</u>	
24a. REG'D BY REGISTRAR <u>Mar 1 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Items 3.5 Film 6236 2-13-60 et
2277 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>2½ hrs.</u>		d. STREET ADDRESS <u>2712 30th St. SE Apt. B 364</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL NNM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grover Cleveland SCHNELL</u>		4. DATE OF DEATH Month Day Year <u>February 7 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-85</u>
9. AGE (In years last birthday) yrs. <u>74</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Buchanan PADGETT</u>		14. MOTHER'S MAIDEN NAME <u>Arabelle LOCKARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mildred SLAUGHTER (D) same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 February 1960</u> , to <u>7 February 1960</u> , that I last saw the deceased alive on <u>7 February 1960</u> , and that death occurred at <u>1155 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Marshall H. Olson</u> M.D.		DATE SIGNED <u>Feb 9 1960</u>	
PHYSICIAN'S NAME (Type) <u>M.W. OLSON LCDR MC USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>She S. Hines</u> <u>S.H. HINES</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	
ADDRESS <u>2901 14th St. W.D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Note: Sex and given names verified by records of N.S.Naval Hosp.

et

2126

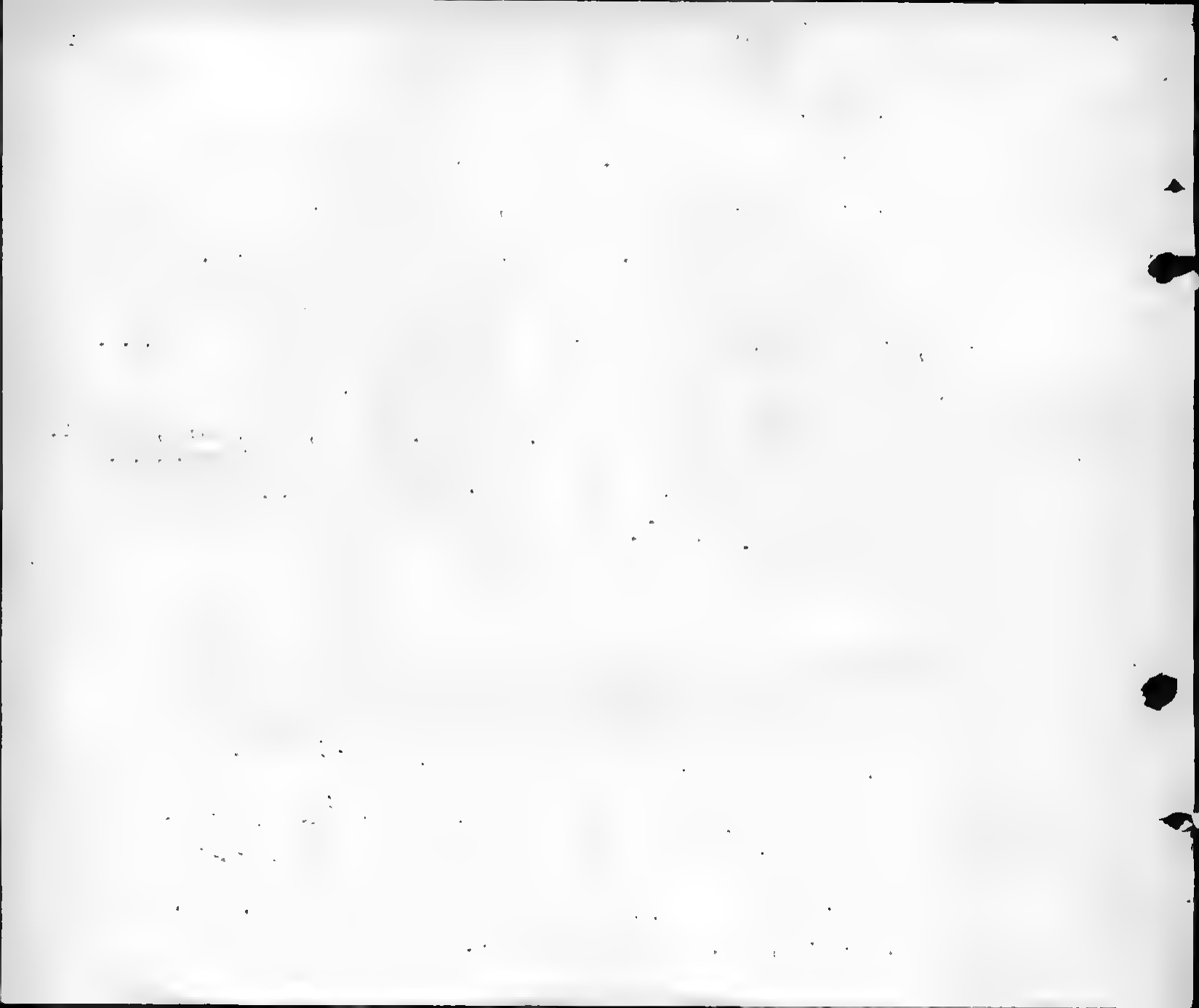
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last SCHULER				4. DATE OF DEATH Month FEB. Day 16 Year 1960			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/68	9. AGE (In years last birthday) 92 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor, Civilian employee of Marie Corps				10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME GODFREY SCHULER				14. MOTHER'S MAIDEN NAME MARY unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mr. Elwood W. Schuler, Dodge House, 20 E St. NW				Address Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. DUE TO (c) 1 yr. 15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 10, 1948 to Feb 16, 1960 that I last saw the deceased alive on Feb 16, 1960 and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9500 Colesville Rd Silver Spring Md DATE SIGNED							
ACTUAL SIGNATURE H. B. OKLEANS M.D.							
PHYSICIAN'S NAME (Type) H. B. OKLEANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/19/60		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

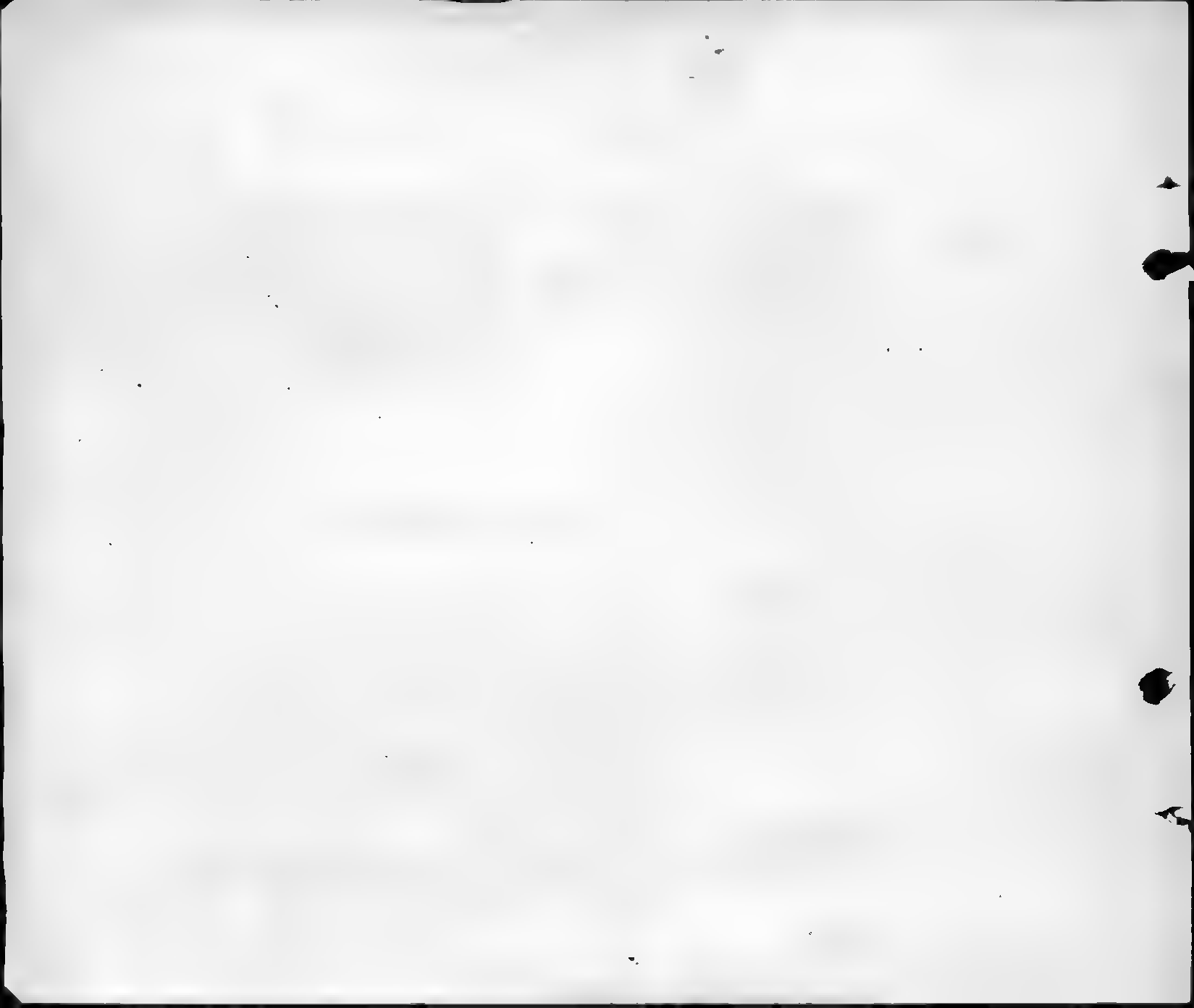


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2155 CERTIFICATE OF DEATH

02251

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 mi. S. Park</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street addr. OR INSTITUTION) <u>2001 CARROLL AVENUE</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Tahoma Park</u>			
				f. STREET ADDRESS <u>1 8001 Carroll Ave</u>			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E</u> Last <u>Seor</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 18, 1912</u>	
				9. AGE (In years last birth day) <u>47</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
				11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>			
13. FATHER'S NAME <u>Harry Seor</u>				14. MOTHER'S MAIDEN NAME <u>Emily Marie Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>1446</u>		17. INFORMANT <u>CLARA H. SEOR</u> Address <u>PO. BOX 1446</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Acc.</u>							<u>sudden</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chr. Deg. Myocarditis</u>							
(c) <u>Anginal Pains - in</u>							<u>2/2/60</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Feb.</u> Day <u>15</u> Year <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/31</u> 19 <u>60</u> , to <u>2/15</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>60</u> , and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above							
22a. SIGNATURE <u>Howard I Mouse</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Howard I Mouse</u>				22d. ADDRESS <u>7030 Carroll Ave Tahoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Feb. 23, 1960</u>		<u>Washington National</u>		<u>Washington Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>254</u> ADDRESS <u>1114</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 23 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Wm S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove center papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

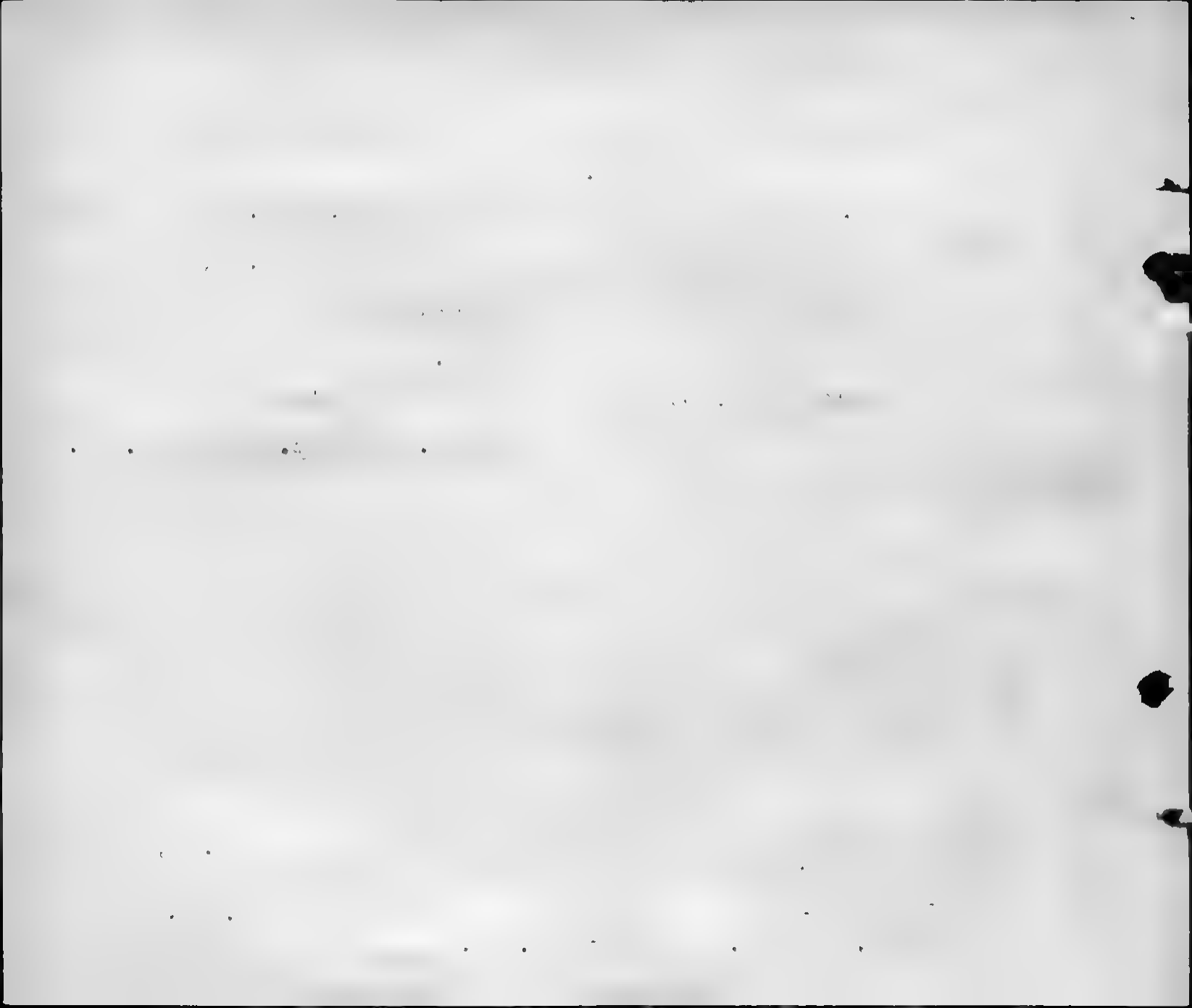
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>1 1/2 hrs.</u>				d. STREET ADDRESS <u>103 Dawson Ave., Apt. 134</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>20 Summit Ct.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Simmie John Shifflett</u>				4. DATE OF DEATH <u>Feb. 27, 1960</u> 19 <u>19</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/16/1898</u> 1898 <u>58</u> 62	
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Mack Shifflett</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Shifflett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>1-16-1898-1898</u>			
17. INFORMANT <u>Mamie A. Shifflett, Rockville, Md.</u>				Address <u>Rockville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-1-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>				22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>			
23. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg, Md.</u>				24. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>			
24a. DATE <u>MAR 1 '60</u>				24b. REGISTRAR'S SIGNATURE <u> </u>			

252



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02253

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>9223 Baltimore Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Andrew</u> Last <u>Sievert</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1932</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u>27</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employment Office N.S. Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis E. Sievert</u>		14. MOTHER'S MAIDEN NAME <u>Christina Gerstner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Brother-in-law</u> Address <u>Beltsville md.</u>		<u>David J. Breewood 4511 Yates Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>fracture of skull</u> Conditions, if any, which gave rise to immediate cause (b) <u>fracture of skull</u> (c) <u>fracture of skull</u> DUE TO <u>fracture of skull</u> cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>16</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury was involved in accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12:30 P.M.</u> <u>2-19-1960</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Adelphi P.D.</u> <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Bosch's Sons</u>		24. REC'D BY REGISTRAR <u>DATE FEB 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		DATE SIGNED <u>2-19-60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the words "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

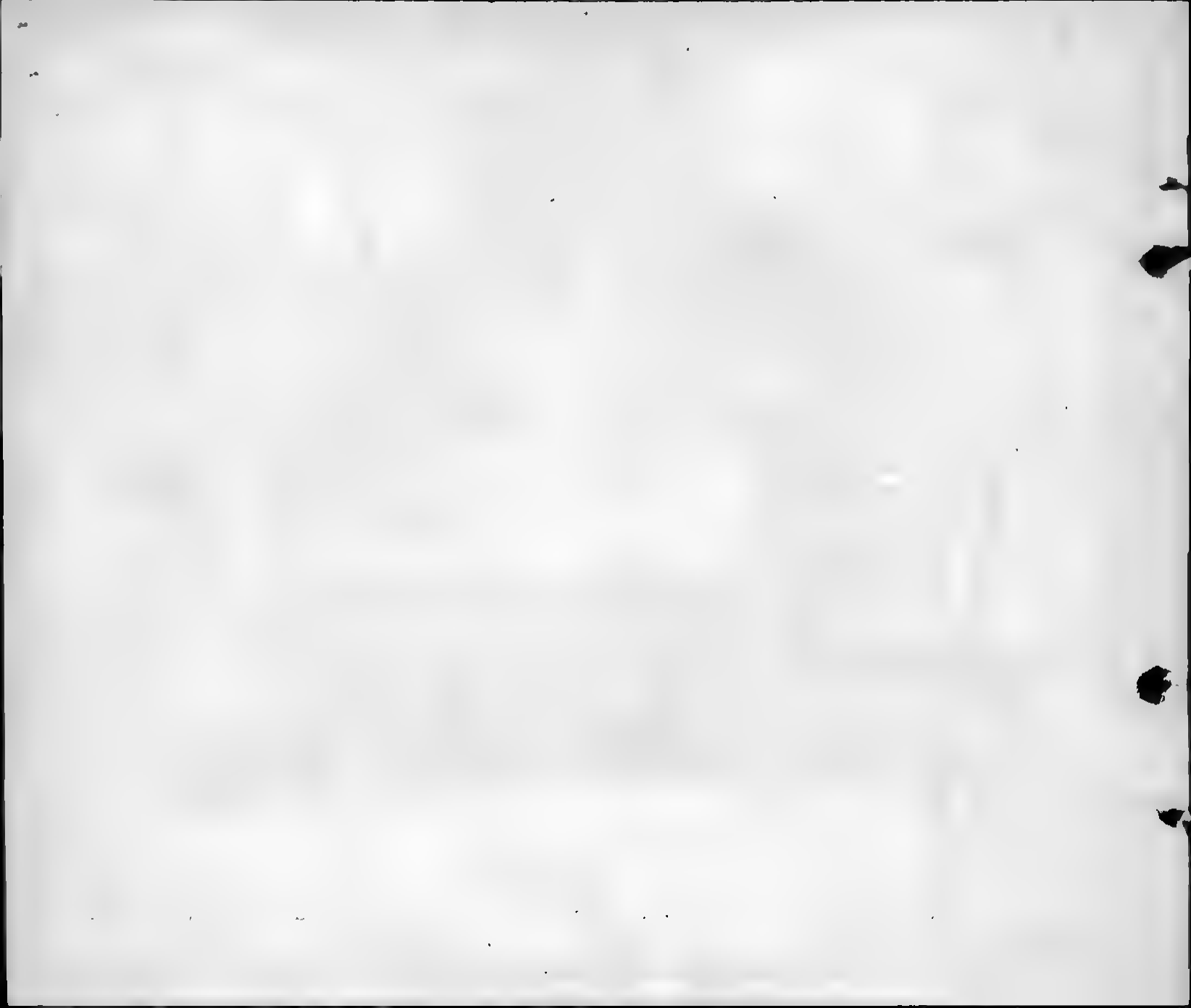
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>9223 Baltimore Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Veneta</u> Middle <u>(HAK)</u> Last <u>Sievert</u>		4. DATE OF DEATH Month <u>2</u> Day <u>-</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-28</u>
9. AGE (in years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspe. Ter. - Stone Straw. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone</u>	
11. BIRTHPLACE (State or foreign country) <u>Knock Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>Stanley Hozalski</u>		14. MOTHER'S MAIDEN NAME <u>Lacie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-35-9545</u>	
17. INFORMANT <u>Sister</u>		Address <u>Baltimore Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Central hemorrhage + laceration</u> 875X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>fracture of skull</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>War passenger in car involved in accident</u>	
20c. TIME OF INJURY Hour <u>12:30</u> a.m. <u>2-19</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Adelphi</u> (County) <u>P.G.</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacobson</u>		4739 <u>Baltimore Ave.</u> <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2278 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 mo. 20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Anne's Sanatorium</u>		d. STREET ADDRESS <u>2169 14th St N.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Frederic</u> Middle <u>Simpson</u> Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 April 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>9</u> Days <u>9</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry P. Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Walter R. Simpson-Bethesda, Md.-Nephew</u>		18. ADDRESS <u>3610 East West Hwy.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarction</u> DUE TO <u>arteriosclerosis</u> (c) <u>Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>2 1/2 hours</u> <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 7.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <u>Mar 15</u> , 19 <u>60</u> , to <u>Feb 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>60</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter R. Simpson</u> M.D.		DATE SIGNED <u>Feb 6 1960</u>	
PHYSICIAN'S NAME (Type) <u>WALTER J. FORET</u>		<u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8103 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nettie Middle SIPKIN Last SIPKIN		4. DATE OF DEATH Month February Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1909
9. AGE (In years last birthday) 50 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Schwartz		14. MOTHER'S MAIDEN NAME Anna Rubin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. George Sipkin	
17. INFORMANT George Sipkin		Address 8103 Eastern Ave., S.S., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST (POST-OP.) DUE TO (c) OVER 6 yrs.			INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERIO-SCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPTEMBER 19, 1958 , to FEB. 22 , 1960, that I last saw the deceased alive on FEB. 22 , 1960, and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5801-16 1/2 St., N.W., Wash., D.C. DATE SIGNED 2-23-60			
ACTUAL SIGNATURE Israel Kessler		M.D. 5801-16 1/2 St., N.W., Wash., D.C.	
PHYSICIAN'S NAME (Type) ISRAEL KESSLER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-24-60	22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden	22d. LOCATION (City, town, or county) (State) Falls Church, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		24a. REC'D BY REGISTRAR DATE FEB 25 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2279

CERTIFICATE OF DEATH

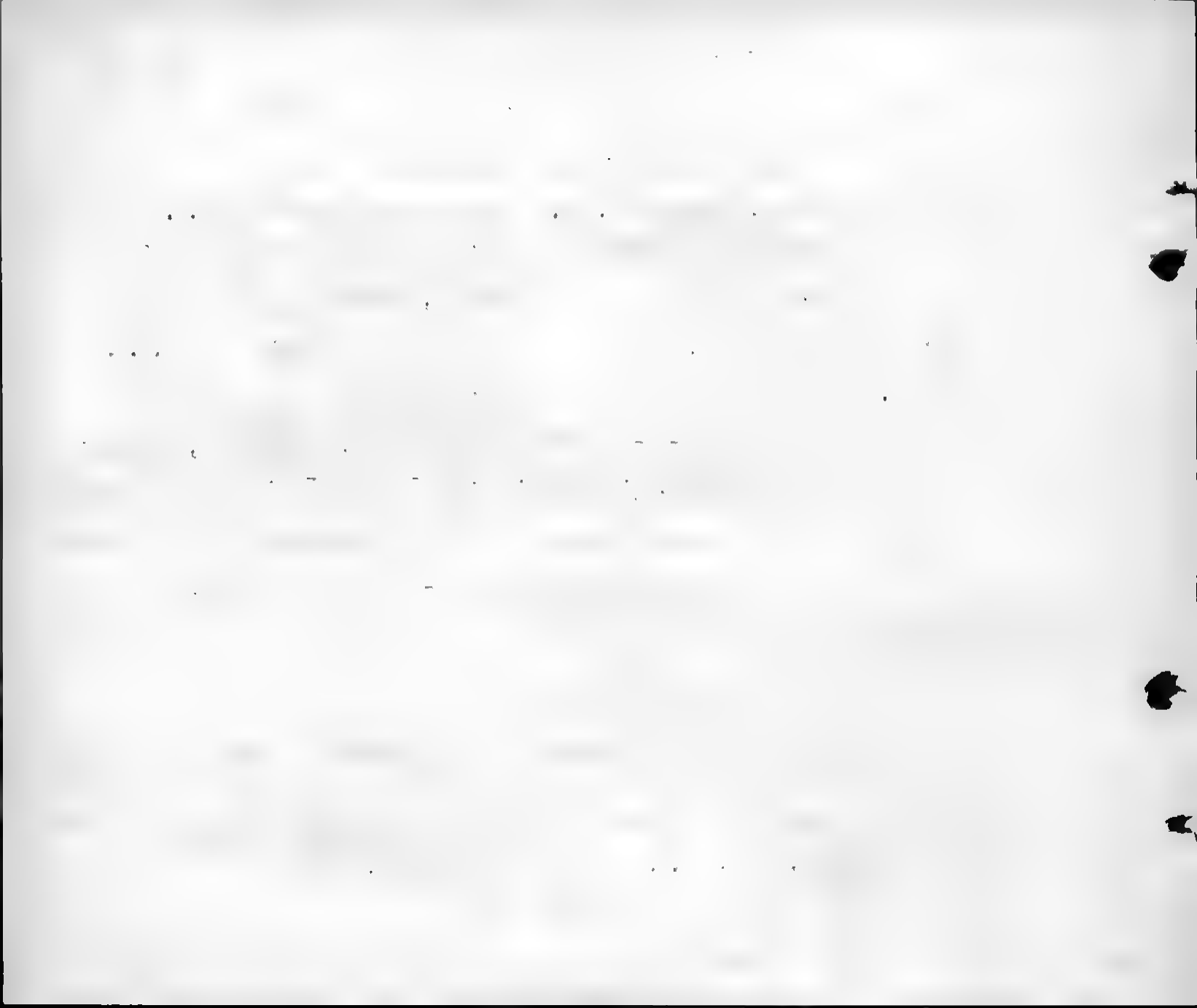
02257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ss on) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 56 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle Thomas Last Smith				4. DATE OF DEATH Month February Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1903	
9. AGE (In years less birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Robert L. Smith				14. MOTHER'S MAIDEN NAME Marilla Allen			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown, (if yes, give war or dates of service)) No				16. SOCIAL SECURITY NO. 196-24-0071			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, empyema, broncho-esophago-pleural fistula; pericarditis 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Epidermoid carcinoma posterior mediastinum DUE TO (c) Epidermoid carcinoma mouth - no local recurrence						INTERVAL BETWEEN ONSET AND DEATH 2 months 8 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 9, 1959 to February 3, 1960 , that I last saw the deceased alive on February 3, 1960 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-4-60 ACTUAL SIGNATURE Seymour C. Nash M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Seymour C. Nash, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cremation		Feb. 5, 1960		Lees Crematory		Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee				ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
						24b. REGISTRAR'S SIGNATURE Conrad S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES NEWMAN SMITH			4. DATE OF DEATH Month Day Year FEBRUARY 2 19 60				
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 4/8/89		9. AGE (In years last birthday) 70 yrs.		10. F UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE NEWMAN					
14. MOTHER'S MAIDEN NAME HARRIETT HALL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.		INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma of uterus (c) Bilateral Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 1/8 to 2/2 1960 that I last saw the deceased alive on 2/2 1960 and that death occurred at 11:05 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND DATE SIGNED 2/2/60							
ACTUAL SIGNATURE _____ M.D.							
PHYSICIAN'S NAME (Type) C. H. LIGON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or county) (State)		22e. REGISTRAR'S SIGNATURE					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR			
24b. REGISTRAR'S SIGNATURE		DATE FEB 10 '60		24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2281 CERTIFICATE OF DEATH

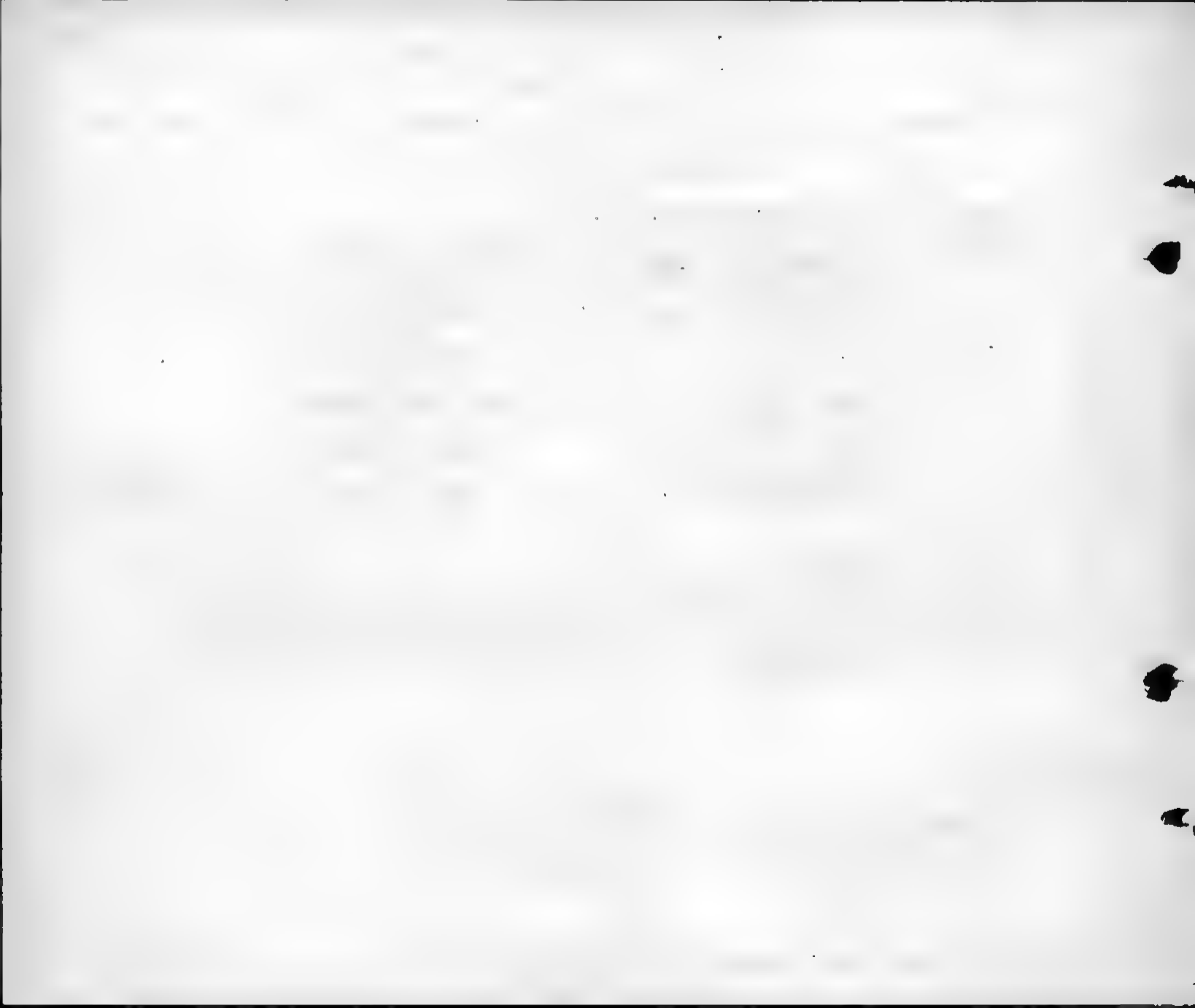
Reg. Dist. No.

02259

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp. Inc.				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS Rt. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Lillie Belle Smith		4. DATE OF DEATH Month February Day 2 Year 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/25/1901		9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Greenwood				14. MOTHER'S MAIDEN NAME Mary Susan Winters				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. NONE				INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) congestive failure DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH 3 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thyroid adenoma, chronic secondary anemia, chronic																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 1955 to Feb 2, 1960 , that I last saw the deceased alive on Feb 2, 1960 , and that death occurred at 6:25 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) MAIN ST. DATE SIGNED 2/2/60																			
ACTUAL SIGNATURE G. F. Meadors, M.D.				M.D. DAMASCUS, MD.				PHYSICIAN'S NAME (Type) G. F. MEADORS, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2/5/60				22c. NAME OF CEMETERY OR CREMATORY WINTERS CEM				22d. LOCATION (City, town, or county) (State) CARROLL COUNTY MD							
23. FUNERAL DIRECTOR'S SIGNATURE D. O. Hartzler, Sons				ADDRESS New Windsor Md.				24a. REC'D BY REGISTRAR FEB 5 '60				24b. REGISTRAR'S SIGNATURE Charles E. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

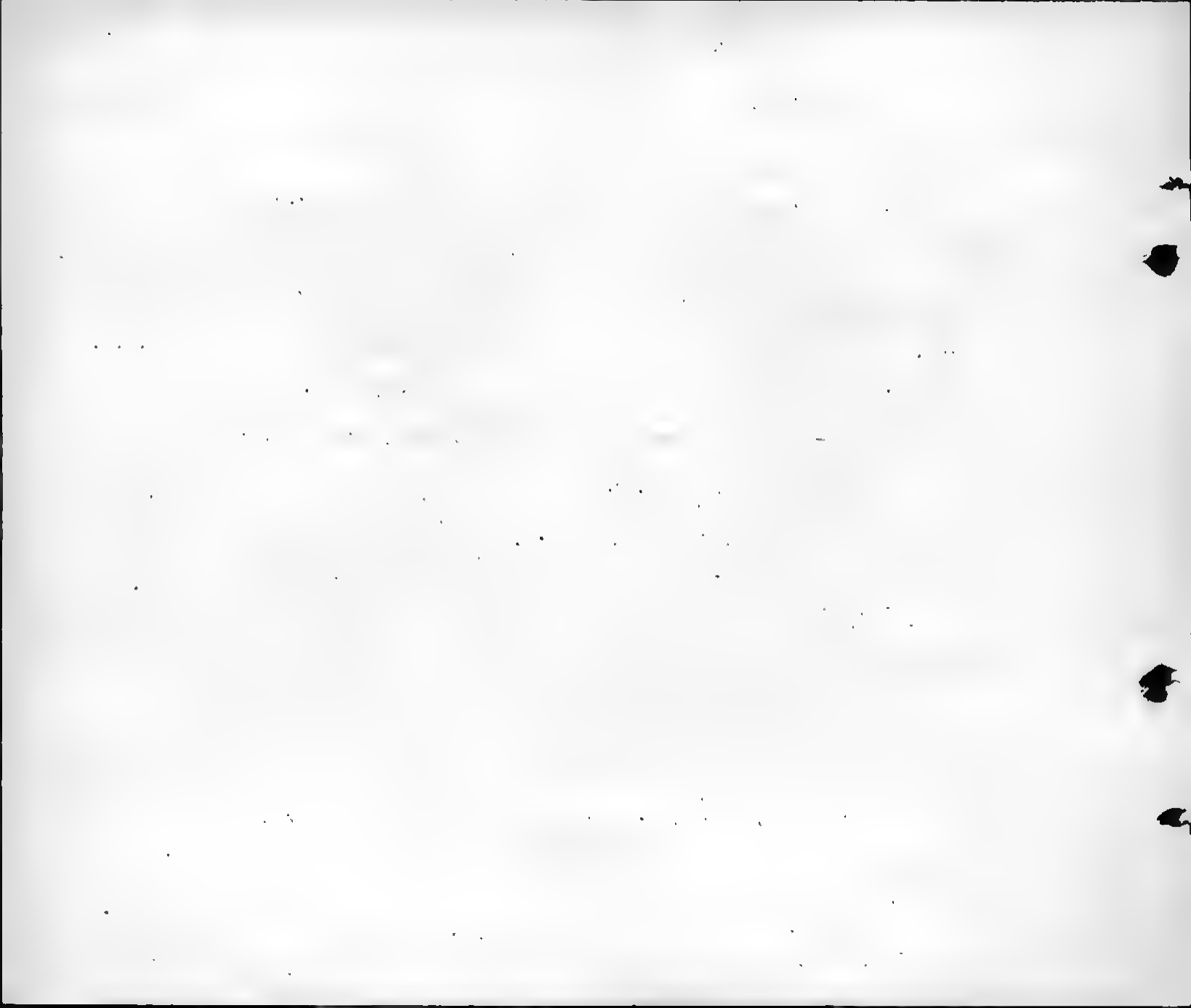
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban hospital		e. STREET ADDRESS 5907 Lone Oak Drive f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle C Last Smith		4. DATE OF DEATH Month February Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H swf.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Buxton, Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mark Rounds		14. MOTHER'S MAIDEN NAME Fannie Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mrs Hattie Stone		Address above (daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial hypertrophy and dilatation DUE TO (c) Rheumatic mitral & tricuspid valvulitis			INTERVAL BETWEEN ONSET AND DEATH 1 week years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patent foramen ovale			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/31, 1960 to 2/8, 1960 , that I last saw the deceased alive on 2/7, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles J. Savarese M.D.		ADDRESS (Street, city or town, state) 4890 BATTERY LA DATE SIGNED 2/8/60	
PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE, M.D.		BETHESDA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 2/10/60	22c. NAME OF CEMETERY OR CREMATORY Prime Grove Cmn	22d. LOCATION (City, town, or county) (State) Washington, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Chry Chase Funeral Home		24a. REC'D BY REGISTRAR Wash. D.C.	24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2283

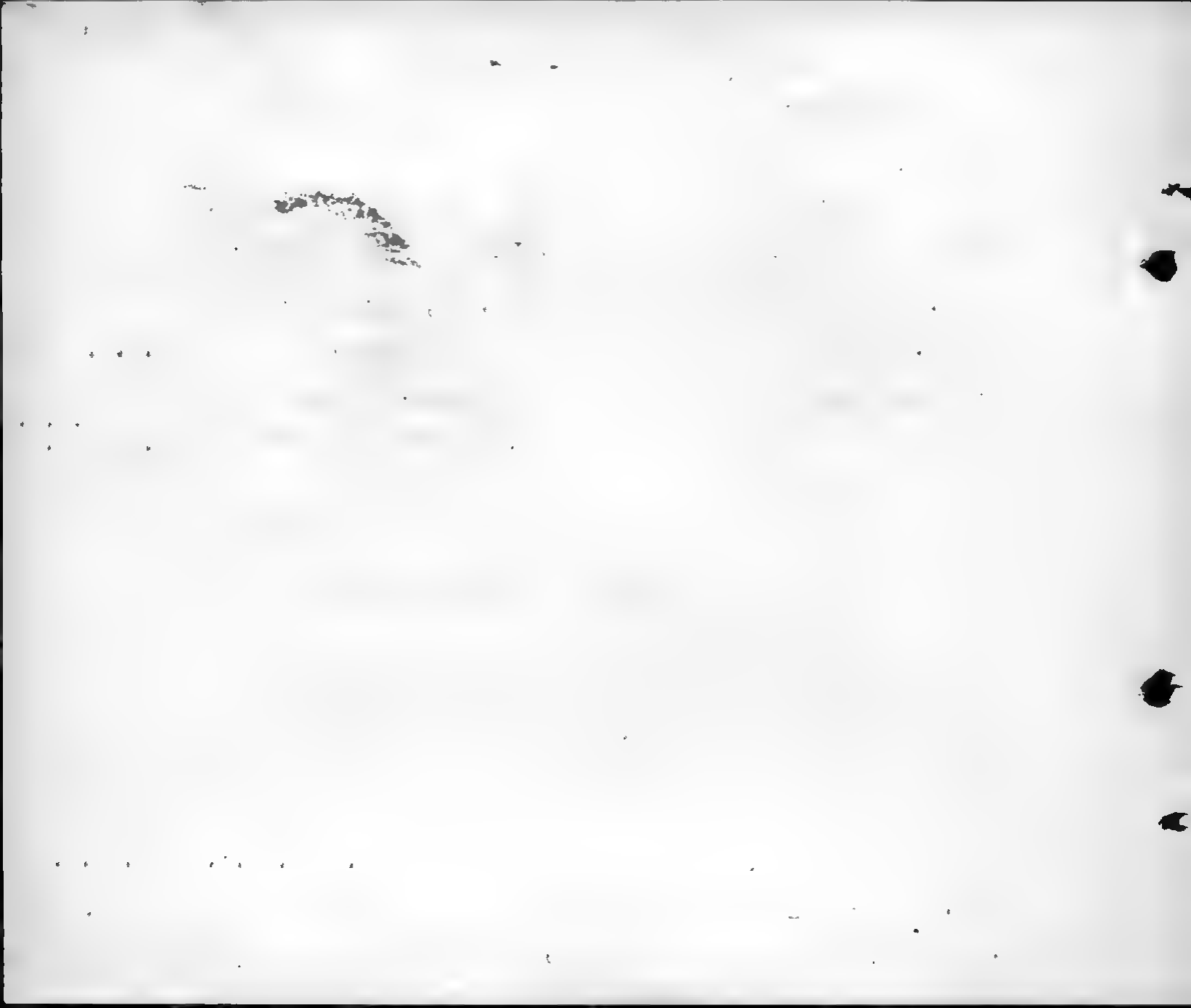
Item 2 M1162, 3-7-60 et

CERTIFICATE OF DEATH

02261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Y a. STATE Maryland b. COUNTY Montgomery D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Home		d. STREET ADDRESS Cathedral Alts. Nr. Gaithersburg, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month February Day 26 Year 19 60	
3. NAME OF DECEASED (Type or print) NELLIE	First SMITH	Middle SMITH	Last SMITH
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV. 26, 1877
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Retired		10b. KIND OF BUSINESS OR INDUSTRY Govt. Retired	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BARTRAM NAUSS		14. MOTHER'S MAIDEN NAME MARGARET YINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
INFORMANT MRS. SARGENT (DAUGHTER)		Address 220 E. 73 ST. N.Y.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 420.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis / Heart disease DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 5 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile dementia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1955 , to Feb 25, 1960 , that I last saw the deceased alive on Feb 21, 1960 , and that death occurred at 3:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Conn Ave, Wash. D.C. DATE SIGNED ACTUAL SIGNATURE Frederic D. Chapman M.D. PHYSICIAN'S NAME (Type) FREDERIC D. CHAPMAN 1150 CONN. AVE. N.W. WASH. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREM.		22b. DATE THEREOF 2-29-60	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowler's Sons		ADDRESS Washington, DC	
24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	



2158 CERTIFICATE OF DEATH

02262

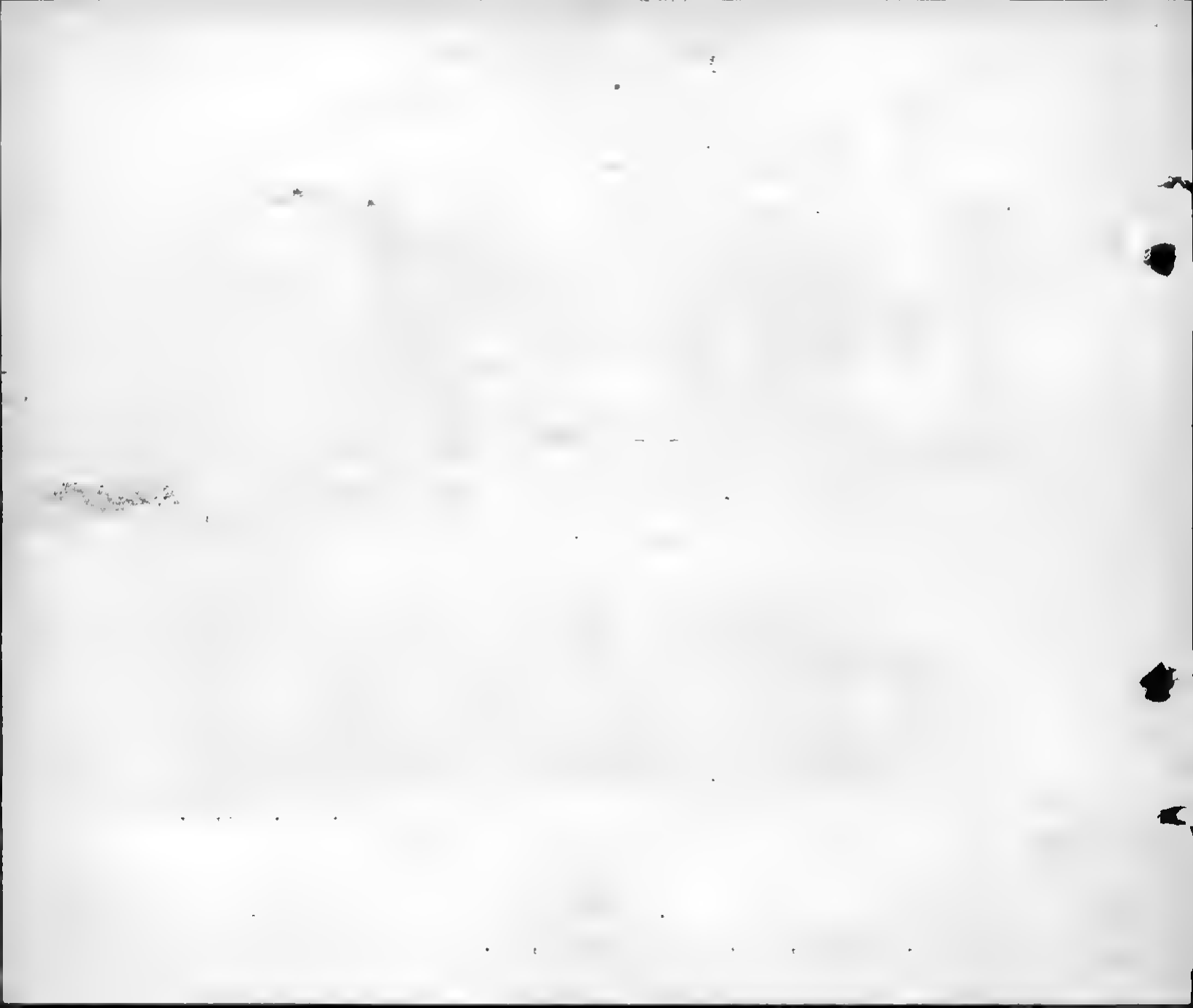
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>109 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Dow</u> Last <u>Smith</u>		DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during those of working life, even if retired) <u>Staff - Natl. Rifle Assoc.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rifle Clubs</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>Clara Clodfelter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>364-14-6549</u>	
17. INFORMANT <u>Mrs Ruth Smith</u>		Address <u>10308-Colesville Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>421</u> DUE TO (b) <u>Myocardial infarction - Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 14, 1960</u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>Feb 14, 1960</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilford D. Meyers</u> M.D.		ADDRESS (Street, city or town, state) <u>8323 Haddon Dr. Tak. Pk., Md.</u> DATE SIGNED <u>2/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2159

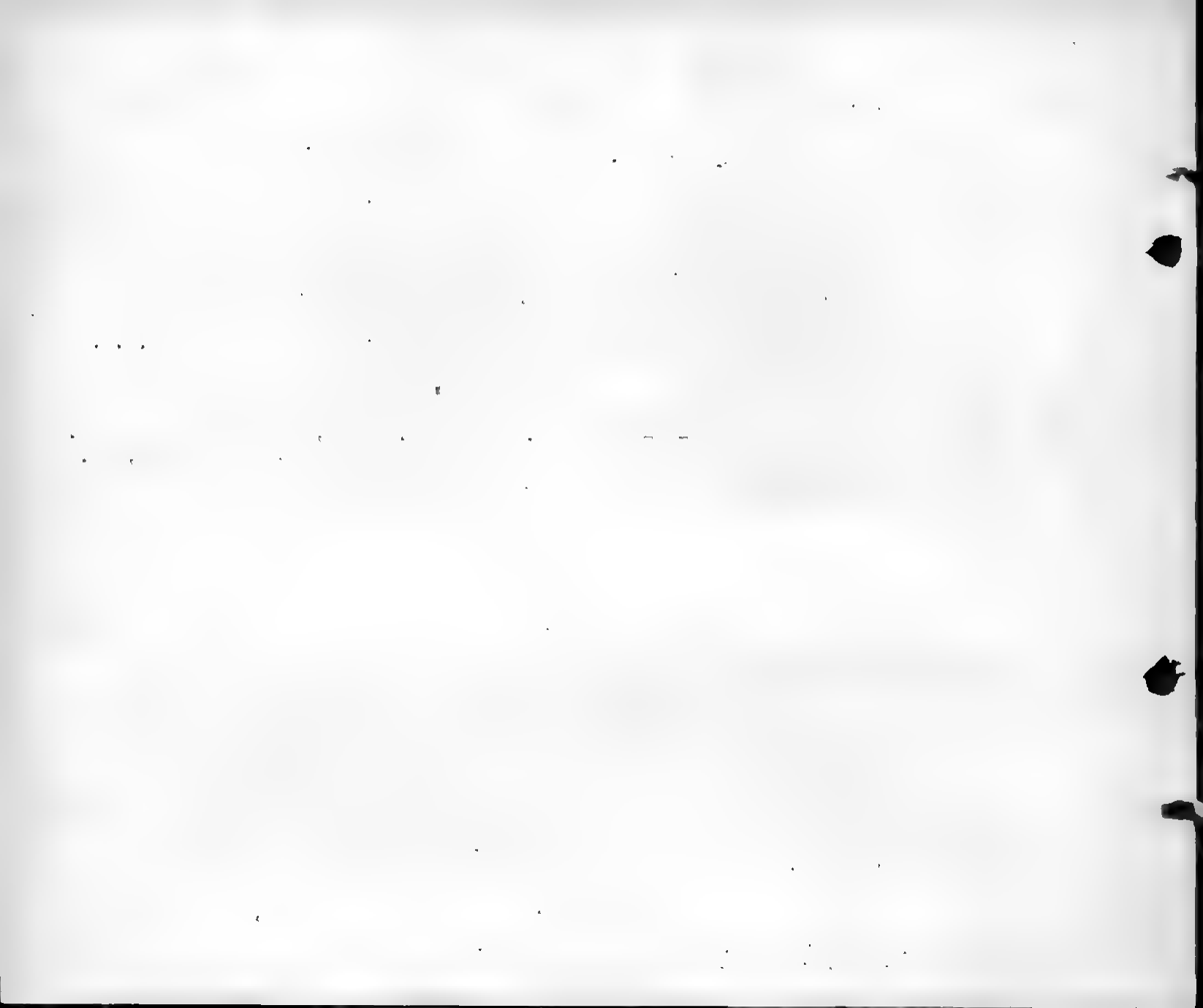
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 514 DOMER AVENUE		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK d. STREET ADDRESS 514 DOMER AVENUE e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM R SMITH		4. DATE OF DEATH Month Day Year FEB 13 1960	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/87
9 AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR (Builder)	11. BIRTHPLACE (State or foreign country) SOUTH CAROLINE
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT SMITH	
14. MOTHER'S MAIDEN NAME LUCY MOSS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO 578-14-9088		17. INFORMANT Address Mr. Charles R. Smith, 1121 Caddington Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS DUE TO 450. - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF THE LUNG.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from MARCH 1958 , to FEB. 13 1960 , that I last saw the deceased alive on FEB. 12 1960 , and that death occurred at 12:50 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE ABRAHAM W. DANISH, M.D.		ADDRESS (Street, city or town, state) 927 PEPHAM DR SILVER SPRING, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS & BURIAL 2/16/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY GRACELAND CEMETERY		22d. LOCATION (City, town, or county) (State) GREENVILLE, SOUTH CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR FEB 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Phipps			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

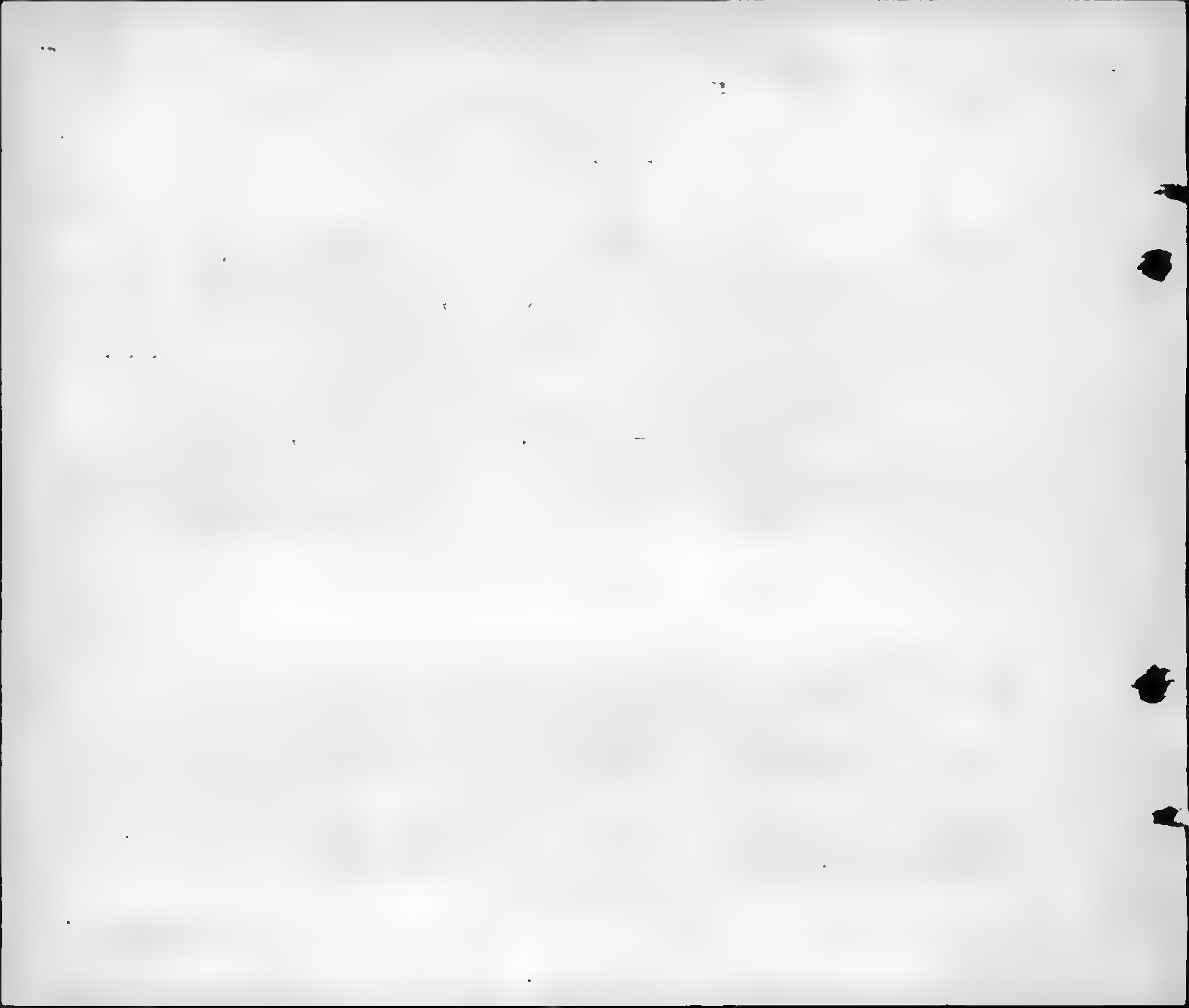
02264

Reg. Dist. No.

2128

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b --- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 944 BONIFANT STREET		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville d. STREET ADDRESS Goshen School Road	
3. NAME OF DECEASED (Type or print) Charles WILLIAM Fenton SNOUFFER		4. DATE OF DEATH Month FEB. Day 24 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1906
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months --- Days ---	11. IF UNDER 24 HRS Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Cycle Shop	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Snouffer	
14. MOTHER'S MAIDEN NAME Lucy Brady		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 577-05-6026		17. INFORMANT Mrs. Josephine Snouffer, Item #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) --- DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
INTERVAL BETWEEN ONSET AND DEATH sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour --- a. m. --- p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Francis J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/60	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Montgomery, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR FEB 29 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File in 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02265

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-2</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood - R-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant View Nursing Home</u>			d. STREET ADDRESS <u>mt Zion</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Phoebe Waters Snowden</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>ere</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1866</u>		9. AGE (In years last birthday) <u>93</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>✓</u>			14. MOTHER'S MAIDEN NAME <u>✓</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Nursing Home</u> Address <u>Stem - 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m. p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington, D. C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschani</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Feb 1 1960</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschani</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION <u>Removal</u>		22b. DATE THEREOF <u>2/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McGuire Funeral Home.,</u>	
				22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rookville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



2285

CERTIFICATE OF DEATH

Reg. Dist. No.

02266
215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 57		d. STREET ADDRESS 6809 Algonquin Ave.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Clara		Middle Alberta		Last SNYDER		4. DATE OF DEATH Month February		Day 2		Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-7-80		9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME David Myers		14. MOTHER'S MAIDEN NAME Alberta James													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) - - - - -		INFORMANT Hospital Records		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematomata, multiple DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from January 27 , 19 60 , to February 2 , 19 60 , that I last saw the deceased alive on February 2 , 19 60 , and that death occurred at 2:55 P.M. , from the causes and on the date stated above.															
ACTUAL SIGNATURE R. G. Galbraith Jr.		M.D.		ADDRESS (Street, city or town, state) U. S. Naval Hospital		DATE SIGNED 2-3-60									
PHYSICIAN'S NAME (Type) R. G. GALBRAITH, LT, MC, USN				Bethesda 14, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 2-4-60		22b. DATE THEREOF 2-4-60		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) Whitemarsh Pa.									
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline									

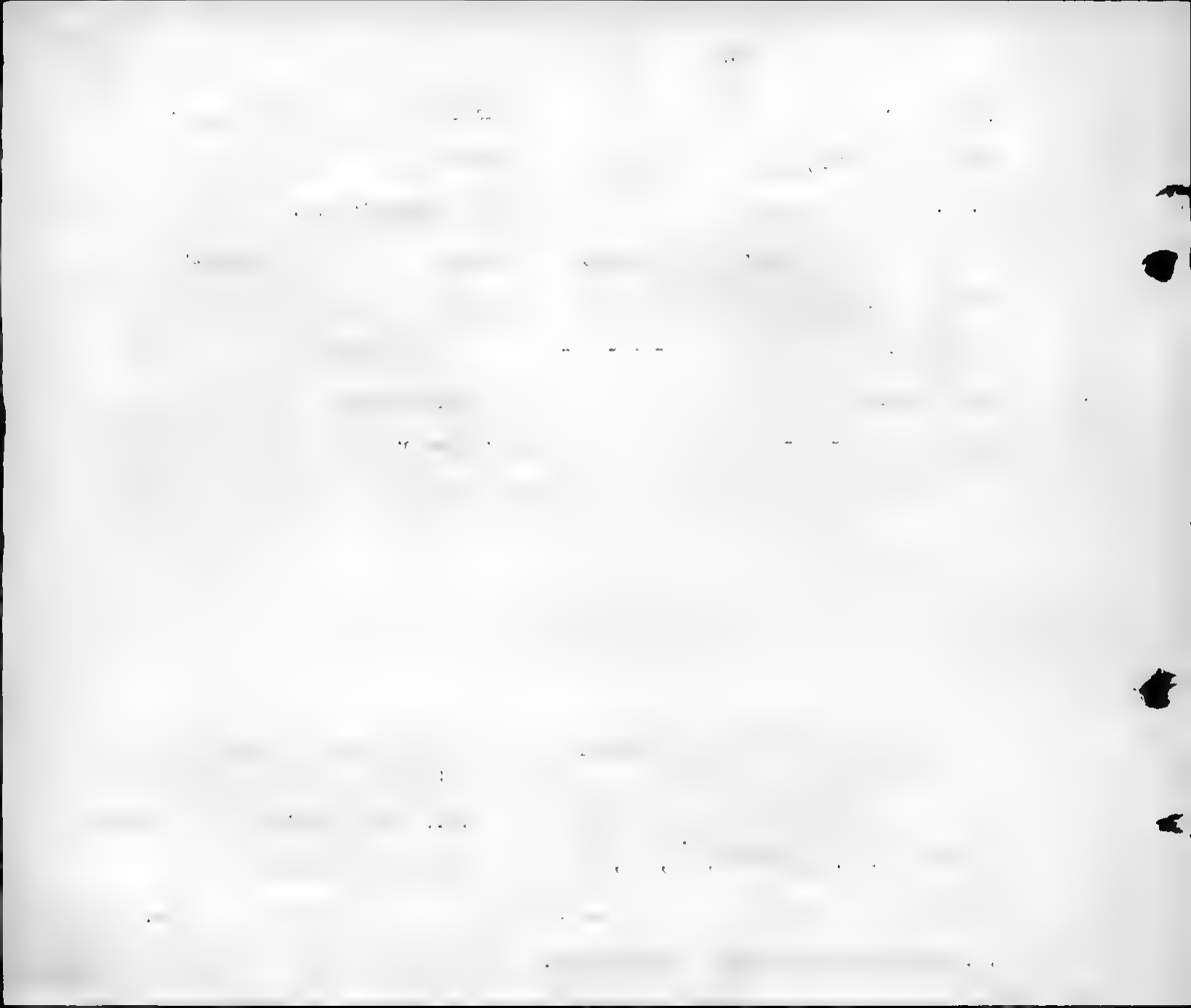
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2286

CERTIFICATE OF DEATH

Reg. Dist. No.

02267

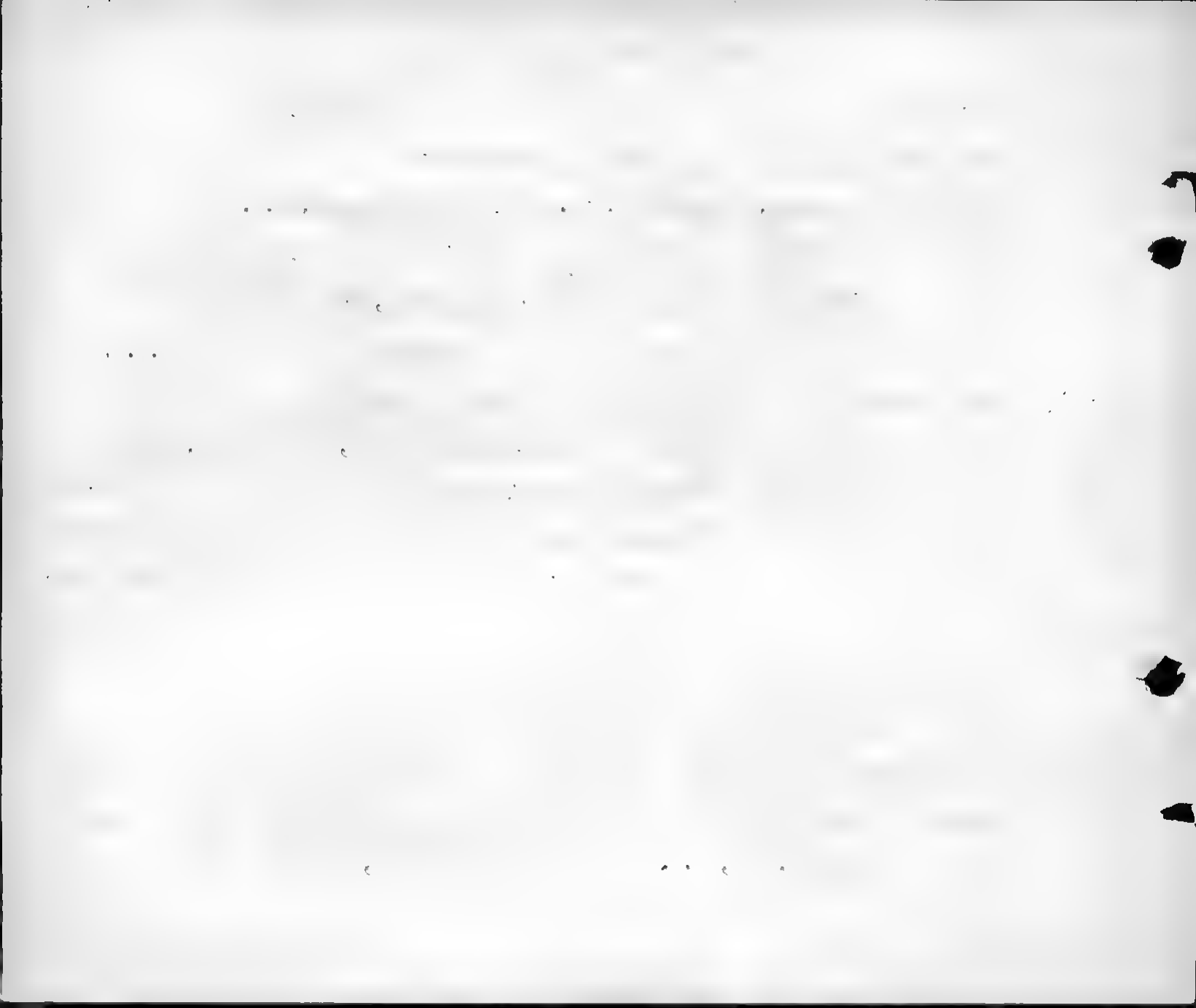
1 PLACE OF DEATH COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 1618 Myrtle Street, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First David Middle Benjamin Last Sosnik		4. DATE OF DEATH Month February Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1943
9. AGE (in years last birthday) 16 yrs		10. IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Harry Sosnik		14 MOTHER'S MAIDEN NAME Sophia Feldmann	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 421.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hypertension DUE TO (c) Pulmonary Vascular Obstruction		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 6 months Over 6 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 24, 1960 to February 27, 1960 that I last saw the deceased alive on February 27, 1960 and that death occurred at 10:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel M. Fox		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Samuel M. Fox, M.D.		DATE SIGNED 2/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 29, 1960	
22c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CEMETERY		22d. LOCATION (City, town or county) (State) HILLSIDE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Rung...		ADDRESS 3501-14 ST. N.W.	
24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Robert L. ...	

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



2129

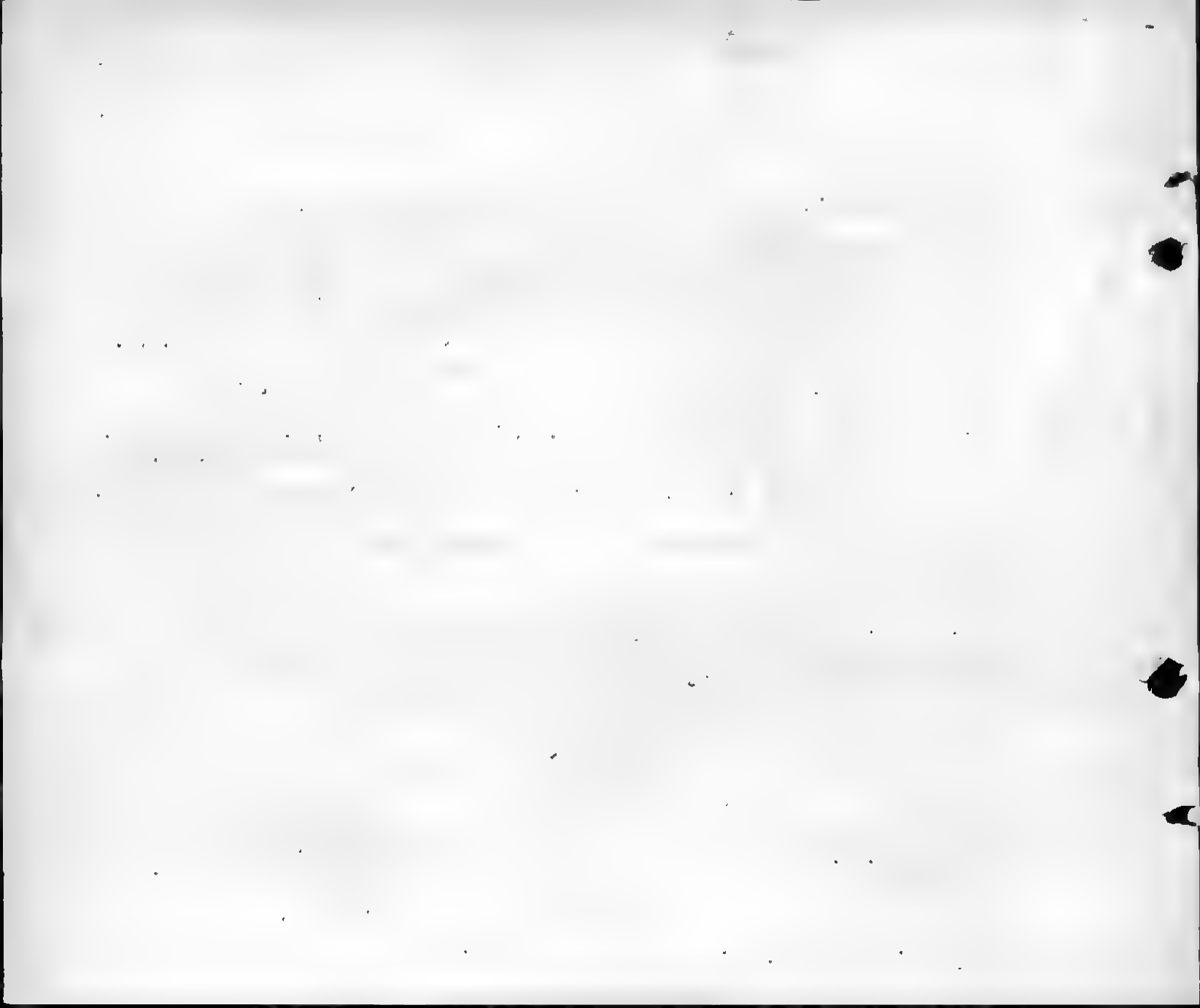
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b Since 1929 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9505 WOODLEY AVE.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 9505 WOODLEY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD ROBINSON STABLER First Middle Last		4. DATE OF DEATH FEBRUARY 15 19 60 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/57
9. AGE (In years last birthday) 102		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist (retired)		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBINSON STABLER		14. MOTHER'S MAIDEN NAME MARY HARTSHORNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. E. Kenneth Stabler, 9505 Woodley Ave.		Address Forest Glen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary insufficiency & occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary arteriosclerosis DUE TO (c) indefinite		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) secondary effects of advanced age (age 102)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/60 , 19 60 , to 2/15/60 , 19 60 , that I last saw the deceased alive on 2/15/60 , 19 60 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. L. Marston		ADDRESS (Street, city or town, state) E. L. Marston, M.D., 800 Pershing Drive, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) E. L. Marston		DATE SIGNED 2/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/18/60	
22c. NAME OF CEMETERY OR CREMATORY WOODSIDE CEMETERY		22d. LOCATION (City, town, or county) (State) BRINKLOW, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARREN E. PUMPHREY, INC. Raymond A. Giska		24a. REC'D BY REGISTRAR FEB 18 '60 DATE	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2287

CERTIFICATE OF DEATH

Reg. Dist. No.

02263

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last SHERRI DARLENE STEVENSON		4. DATE OF DEATH Month Day Year FEBRUARY 10 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/60	9. AGE (In years last birthday) yrs. 9	IF UNDER 1 YEAR Months Days Hours Min. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES JUNIOR STEVENSON		14. MOTHER'S MAIDEN NAME LIZA JANE WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NONE		16. SOCIAL SECURITY NO. NONE		INFORMANT HOSPITAL RECORDS Address OLNDY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity and Immaturity Bilateral Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2/1 1960 to 2/10 1960	
20f. (City or town) SANDY SPRING, MARYLAND		(County)		(State)	
21. I certify that I attended the deceased from 2/1 1960 to 2/10 1960 that I last saw the deceased alive on 2/10 1960 , and that death occurred at 6:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND DATE SIGNED 2/11/60					
ACTUAL SIGNATURE C. H. LIGON, M. D.		M.D.			
PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		SANDY SPRING, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-60		22c. NAME OF CEMETERY OR CREMATORY Hayes Farm	
22d. LOCATION (City, town, or county) (State) Barnesville Md.		22e. REC'D BY REGISTRAR DATE FEB 15 '60		22f. REGISTRAR'S SIGNATURE Charles A. Hinkle	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Hilton		ADDRESS Barnesville Md.			

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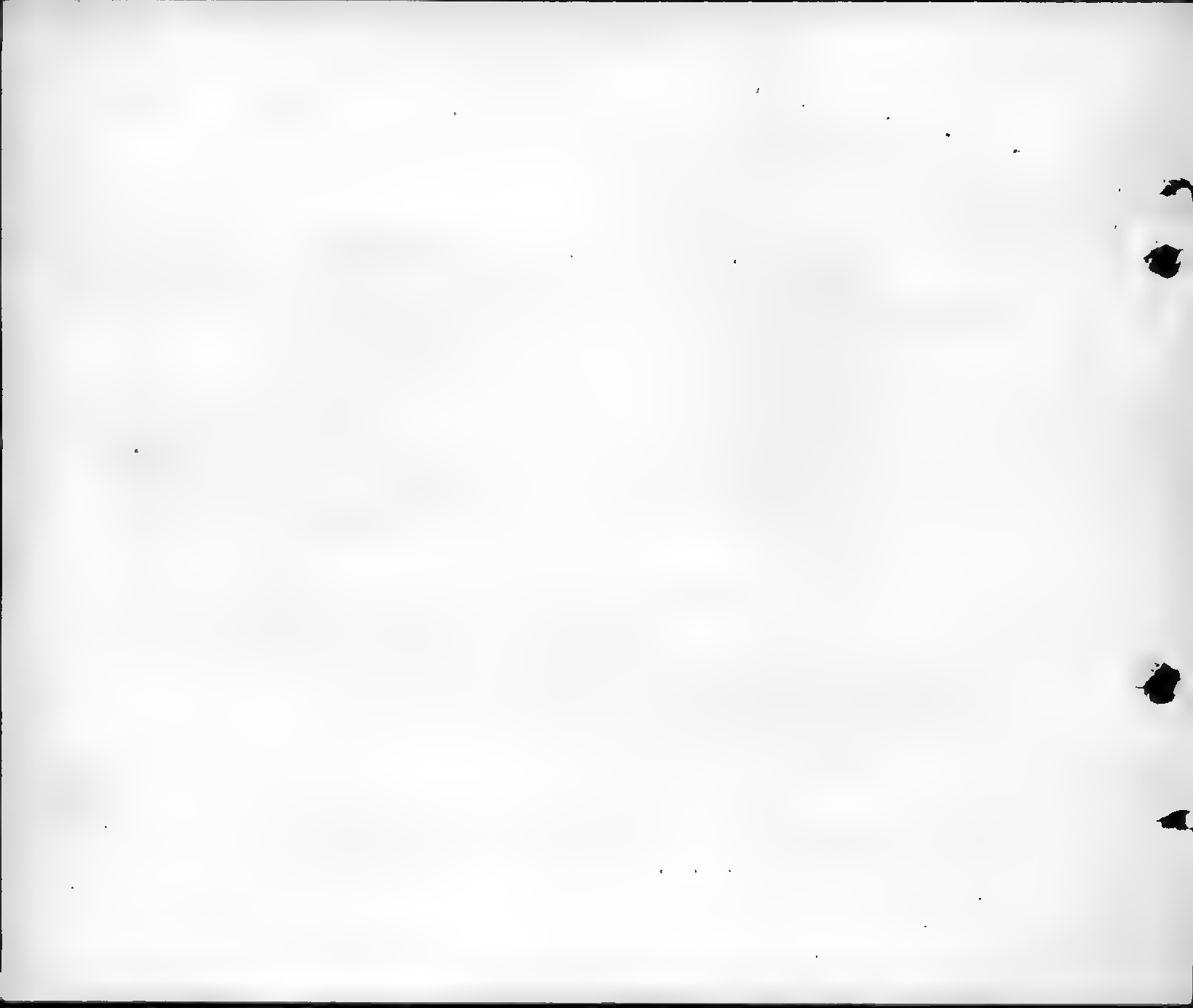
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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



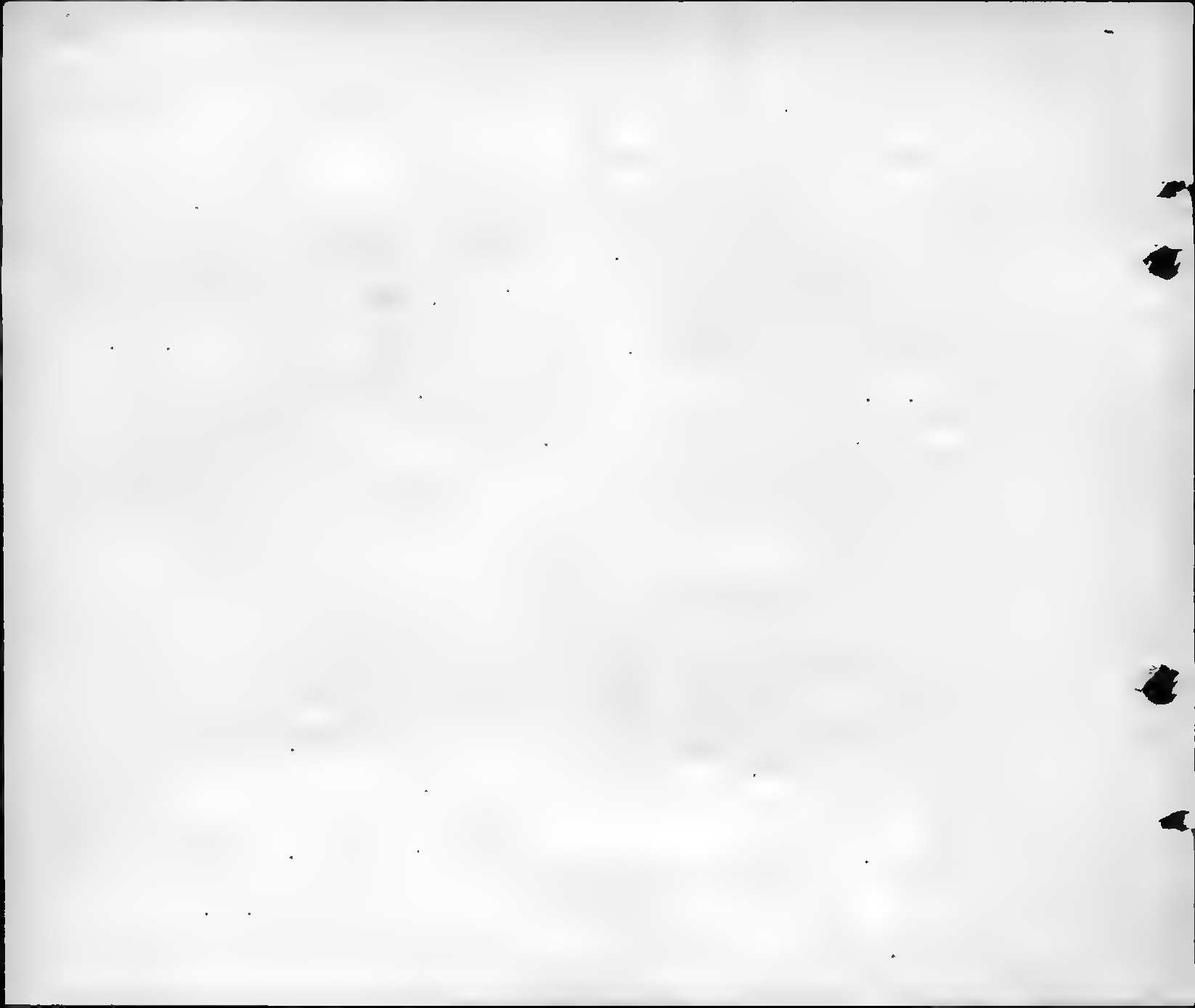
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2288 **CERTIFICATE OF DEATH**

02270

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Nursing Home				e. STREET ADDRESS 7501 Persimmon Tree Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLY Middle C. Last STONE				4. DATE OF DEATH Month February Day 8, Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1861	
9. AGE (in years last birthday) 98 yrs.		IF UNDER 1 YEAR Months 5 Days 18		IF UNDER 24 HRS Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part Owner				10b. KIND OF BUSINESS Marriages			
11. BIRTHPLACE (State or foreign country) Stoneyhurst Stone Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John D. W. Moore				14. MOTHER'S MAIDEN NAME Sara B. Coltman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 220-32-5527			
17. INFORMANT J. Dunbar Stone- Item #2 - Son				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
INTERVAL BETWEEN ONSET AND DEATH 1 day 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from February 51 to Feb. 8, 19 60 , that (I) (we) last saw the deceased alive on Feb. 7 19 60 , and that death occurred 4:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Angle				22b. DATE 2/8/60			
22c. PHYSICIAN'S NAME (Type) Robert G. Angle				22d. ADDRESS 5009 Del Ray Ave., Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-60		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR FEB 9 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



2176

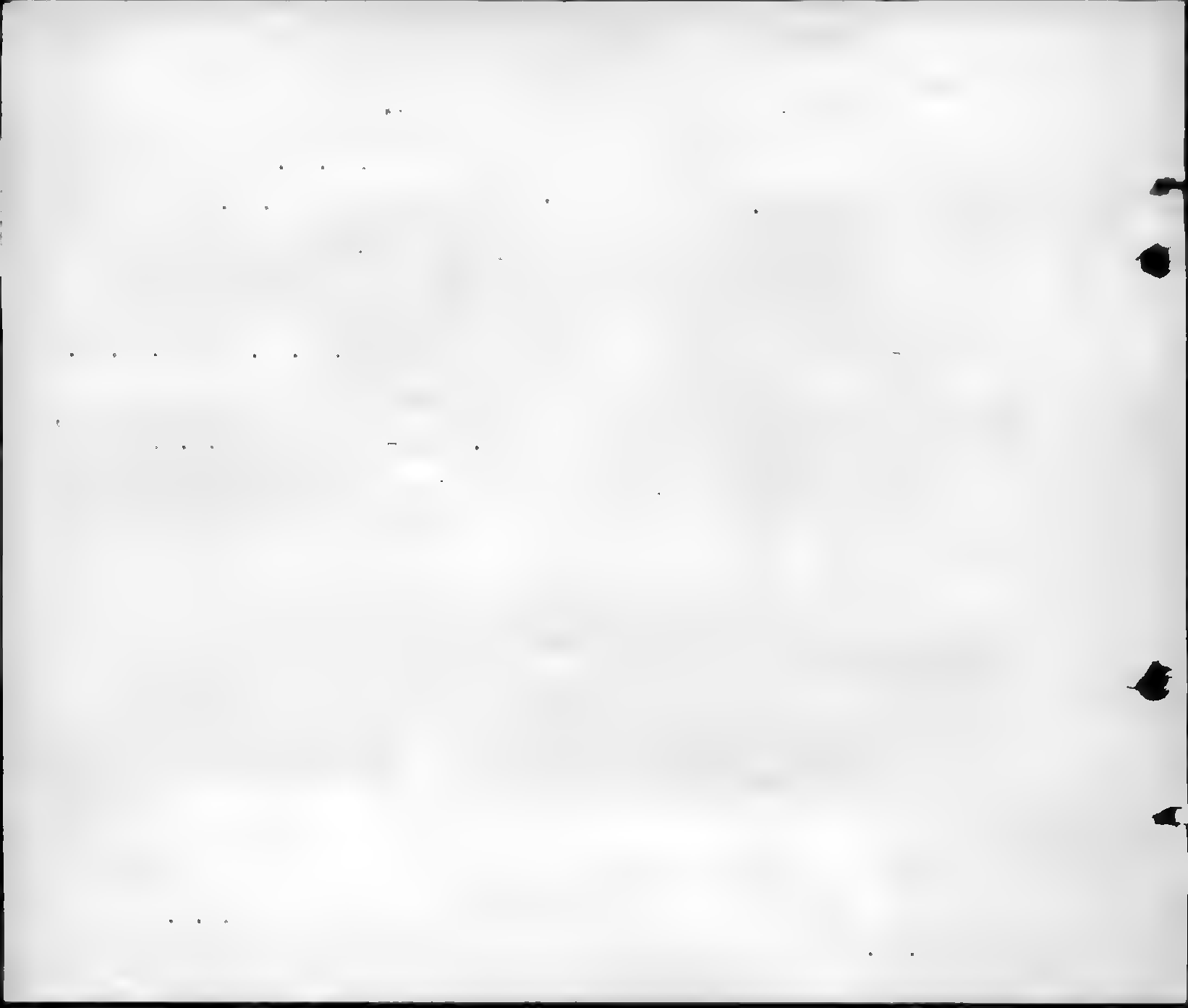
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02271

CERTIFICATE OF DEATH

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanit.		d. STREET ADDRESS 1300 Iris Street N. W.	
3. NAME OF DECEASED (Type or print) First Ernest Middle B Last Swingle		4. DATE OF DEATH Month Feb Day 13 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/1878 1868
9. AGE (In years last birthday) 81 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Carpenter		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO none	
17. INFORMANT Roy L. Cobb-1300 Iris St. N. W.		Address Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO TERMINAL PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Accident DUE TO Artmi-sclerosis (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 1/2 mos 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 12/8/1959 to 2/13/1960 , that (I) (we) lost saw the deceased alive on 2/13/1960 , and that death occurred on 2/13/1960 , from the causes and on the date stated above.			
22a. SIGNATURE Francis X Richardson		22b. ADDRESS 11412 Viers Mill Rd. White Mt.	
22c. PHYSICIAN'S NAME (Type) Francis X Richardson		22d. ADDRESS 11412 Viers Mill Rd. White Mt.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		25a. REC'D BY REGISTRAR FEB 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



FOR STATE
HEALTH DEPT.

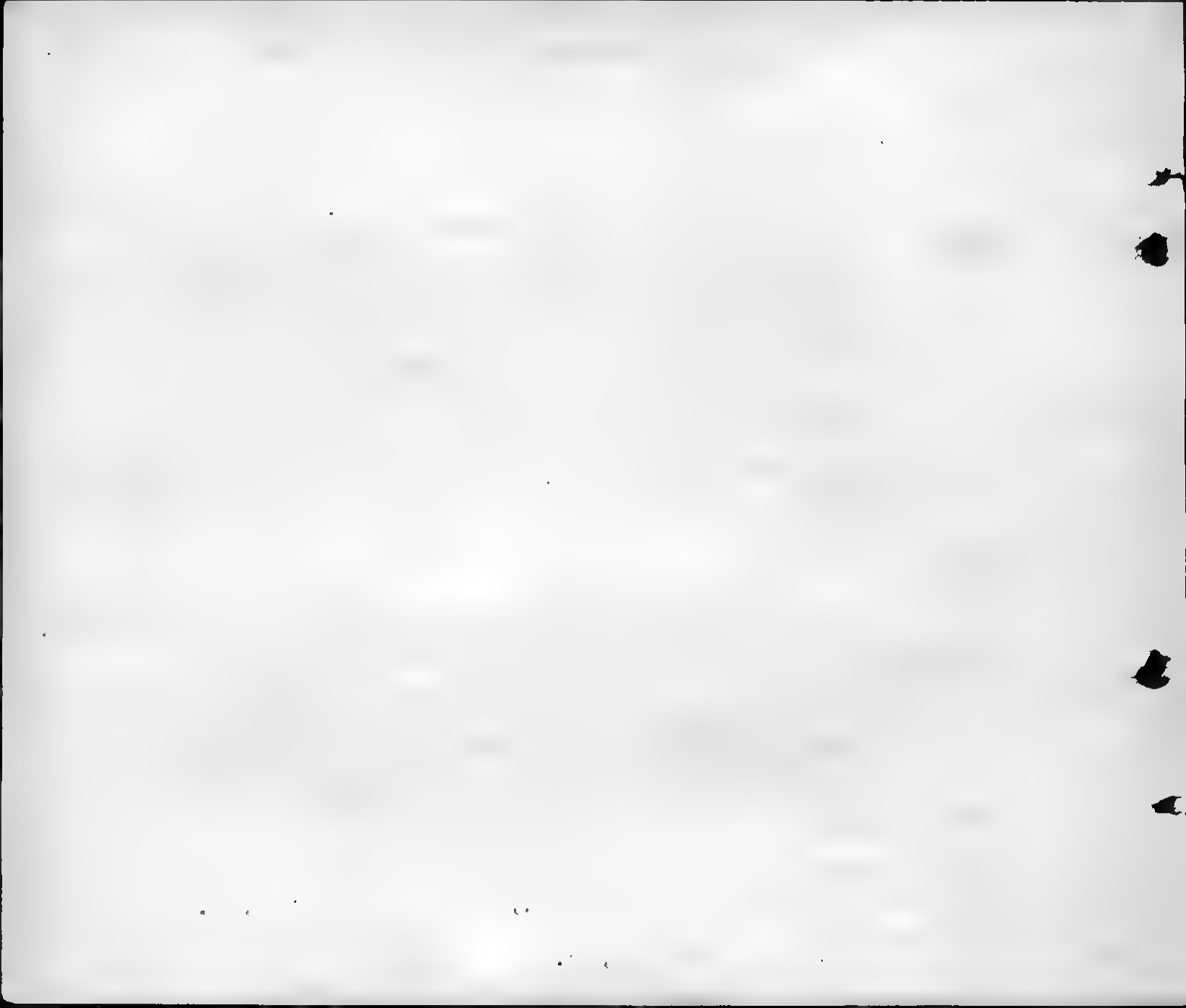
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12272

2289

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville R-2</u> c. LENGTH OF STAY IN TB <u>22 yrs</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville R-2</u> d. STREET ADDRESS <u>Seven Locke Rd</u>		
3. NAME OF DECEASED (Type or print) <u>Emily Ann Thomas</u> First Middle Last 4. DATE OF DEATH <u>Feb 6 1960</u> Month Day Year			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-1894</u>		9. AGE (in years last birthday) <u>66 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>
13. FATHER'S NAME <u>Richard Miles</u>			14. MOTHER'S MAIDEN NAME <u>Rose Lee Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Jerome Baker - Dtn 2</u>		
17. INFORMANT <u>Jerome Baker - Dtn 2</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Valvular Heart disease</u> (c) <u>cause lost.</u> DUE TO					
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosch</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Brosch M</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-6-60</u>		
22a. BURIAL, CREMATION, RITUAL (Specify)		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>	
				22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surdick</u> ADDRESS <u>Rockville, Md.</u>			24a. REC'D BY REGISTRAR <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2290

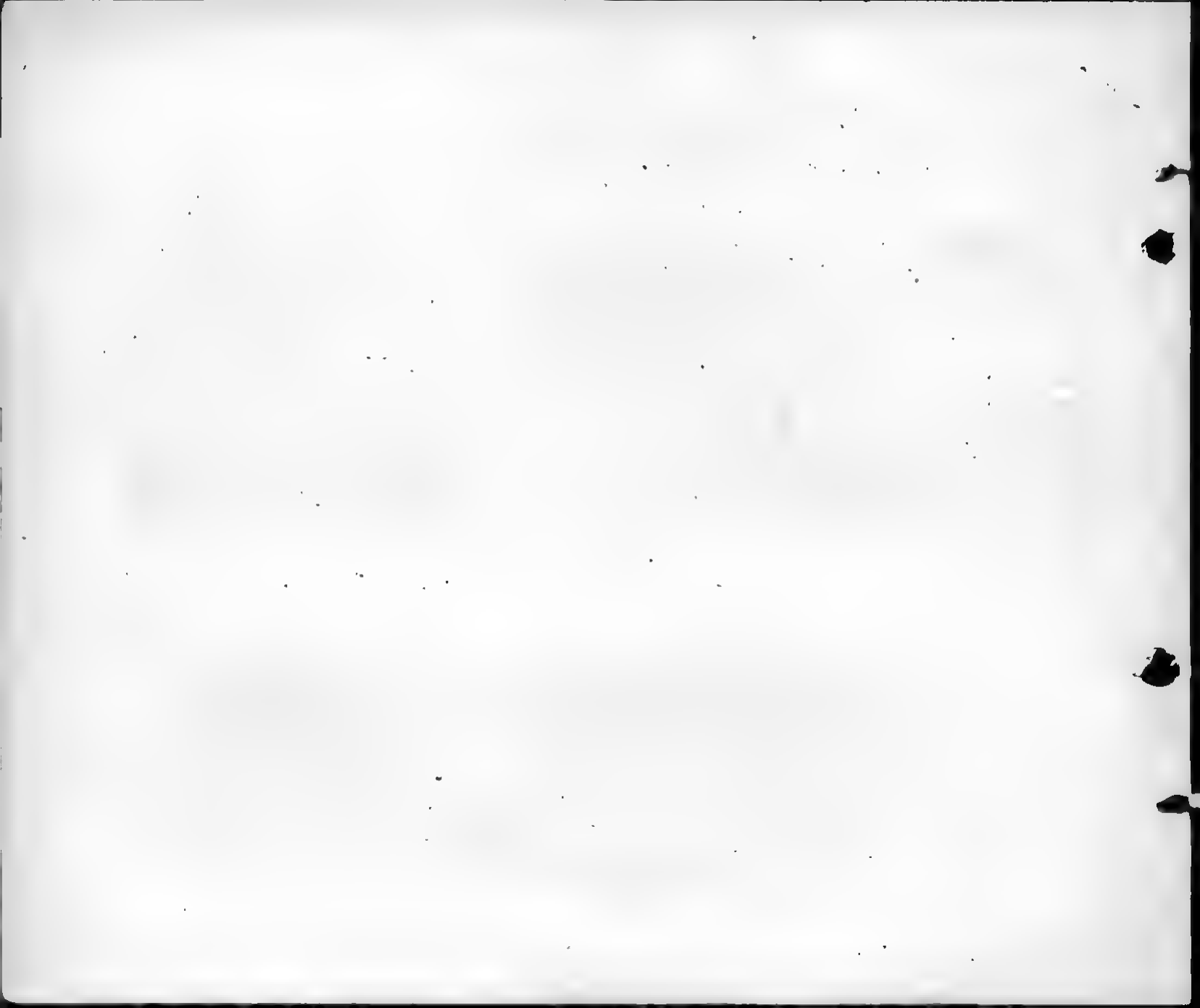
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>44 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Maryland Thompson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 30, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Andrew Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Fox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>678-20-9573</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>myocardial hypertrophy dilation</u> (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>same</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/20/60</u> , 19 <u>60</u> , to <u>2/22/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/21/60</u> , 19 <u>60</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Edward S. Witowski, Jr.</u>		DATE SIGNED <u>2/23/60</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Witowski, Jr.</u>		<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>TYSON WHEELER Funeral Home</u>		24a. REC'D BY REGISTRAR <u>1331 E. Montg. Ave. Rockville, Md.</u>	
		24b. REGISTRAR'S SIGNATURE <u>Cashin S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2291

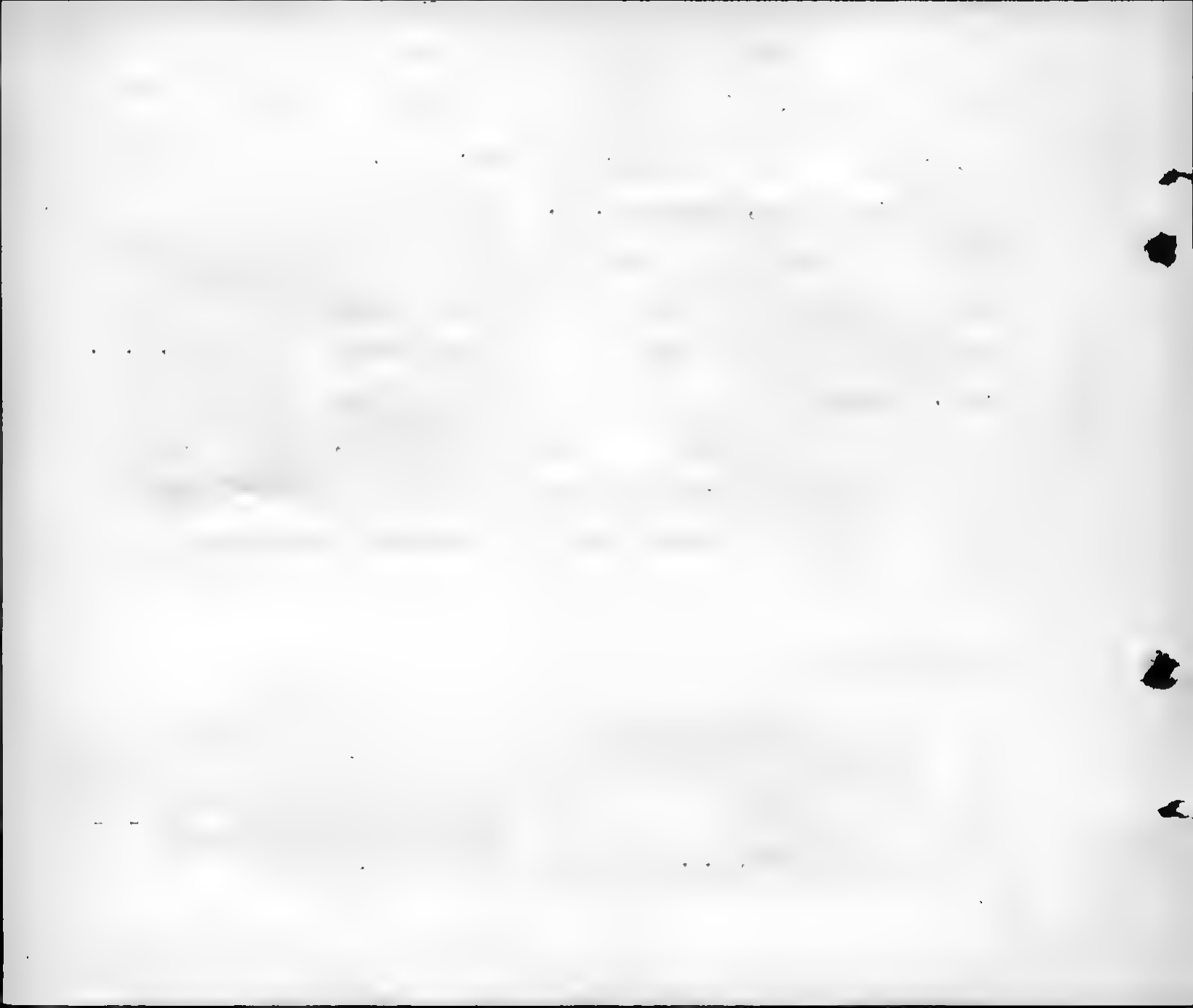
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eau Gallie 7, 48X3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 110 North Oak Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leslie Middle Ann Last Thompson			4. DATE OF DEATH Month February Day 19 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1946		9. AGE (In years last birthday) 13 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Dan F. Thompson		
14. MOTHER'S MAIDEN NAME Geraldine Brown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. None			INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Operative repair of Ventricular septal defect DUE TO (c) 30 hours					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from February 6, 1960 , to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred at 9:34 P. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Roland Folse,		M.D. The Clinical Center		DATE SIGNED 2-20-60	
PHYSICIAN'S NAME (Type) Roland Folse, M.D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-23-60		22c. NAME OF CEMETERY OR CREMATORY LAUGALLIE FLA.	
23. FUNERAL DIRECTOR'S SIGNATURE Rigdon Funeral Home		ADDRESS 816 H St. NE Wash DC		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
				24b. REGISTRAR'S SIGNATURE C. J. S. K. R.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2160

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>1760 Euclid ST N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Edith Waugh Turnley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1960</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-21-04</u>
9 AGE (In years lost birthday) <u>55</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11 BIRTHPLACE (State or foreign country) <u>United States</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Albert Russell Doss</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Bryant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO. <u>226-18-7269</u>	
17 INFORMANT <u>Edwin R. Turnley</u>		Address <u>1760-Euclid at N.W apt 205 (Son)</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>MESENTERIC THROMBOSIS</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EXTERIORIZATION OF CECUM 1/26/60, RESECTION JEJUNUM, ILEUM, PORTION ASCENDING COLON 2/2/60</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>60</u> , to <u>2/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/2</u> , 19 <u>60</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>6727 16th St N.W.</u> DATE SIGNED <u>2/2/60</u>	
ACTUAL SIGNATURE <u>David Goldenberg</u> M.D.			
PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>		<u>WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 4-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town or county) (State) <u>Lynchburg Va</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>300-4 14th St N.E. Wash DC</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/78

2292

CERTIFICATE OF DEATH

Reg. Dist. No.

02276

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital,		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 617 Stone Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Ida May Tryman First Middle Last 4. DATE OF DEATH Feb. 3 1960 Month Day Year		5. SEX female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH July 14, 1910 9. AGE (In years last birthday) 49 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 11. BIRTHPLACE (State or foreign country) D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Green 14. MOTHER'S MAIDEN NAME Lillie Windcar 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. — 17. INFORMANT Sister - Helen L. Brunner Address Southawn Rockville		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic coma 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Hyperglycemia and acidosis DUE TO (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheobronchitis; toxic nephrosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. H. Hall DATE SIGNED 2/3/60 ACTUAL SIGNATURE W. H. Hall M.D. 1500 Montgomery Ave. Rockville, Md. PHYSICIAN'S NAME (Type) William Hall			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-7-60 22c. NAME OF CEMETERY OR CREMATORY St. Cath. Park Cem. 22d. LOCATION (City, town, or county) (State) Rockville Md.		23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shaulen ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR FEB 9 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

100

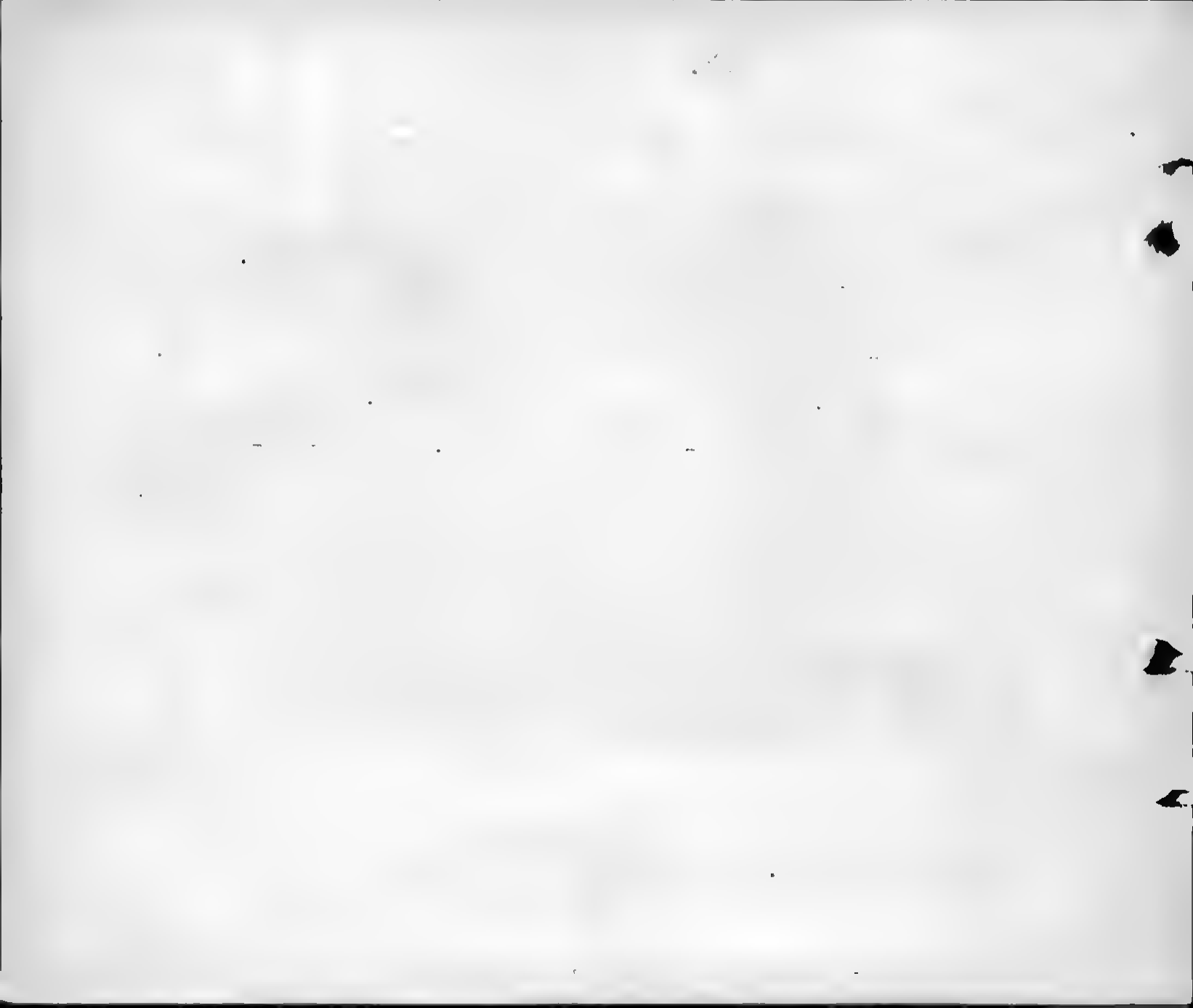
2180 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1945 Lewis Avenue		e. STREET ADDRESS 1945 Lewis Avenue	
3. NAME OF DECEASED (Type or print) First Richard Middle B Last Umstead, Sr		4. DATE OF DEATH Month Feb. Day 28 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/98
9. AGE (In years last birthday) 61 yn		10. IF UNDER 1 YEAR Months 4 Days 29	11. IF UNDER 24 HRS Hours 29 M n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ranier K. Umstead		14. MOTHER'S MAIDEN NAME Zula L. (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 577-03-1338	
17. INFORMANT Richard B. Umstead-son-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 minutes 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UICRAL GASTROENTERITIS			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 27, 1960 to FEB 28, 1960 , that I last saw the deceased alive on FEB 28, 1960 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenburger M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 310 West Montg. Ave. 29 Feb 1960	
PHYSICIAN'S NAME (Type) Gordon S. Rosenburger		Rockville, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/3/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2293

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02278

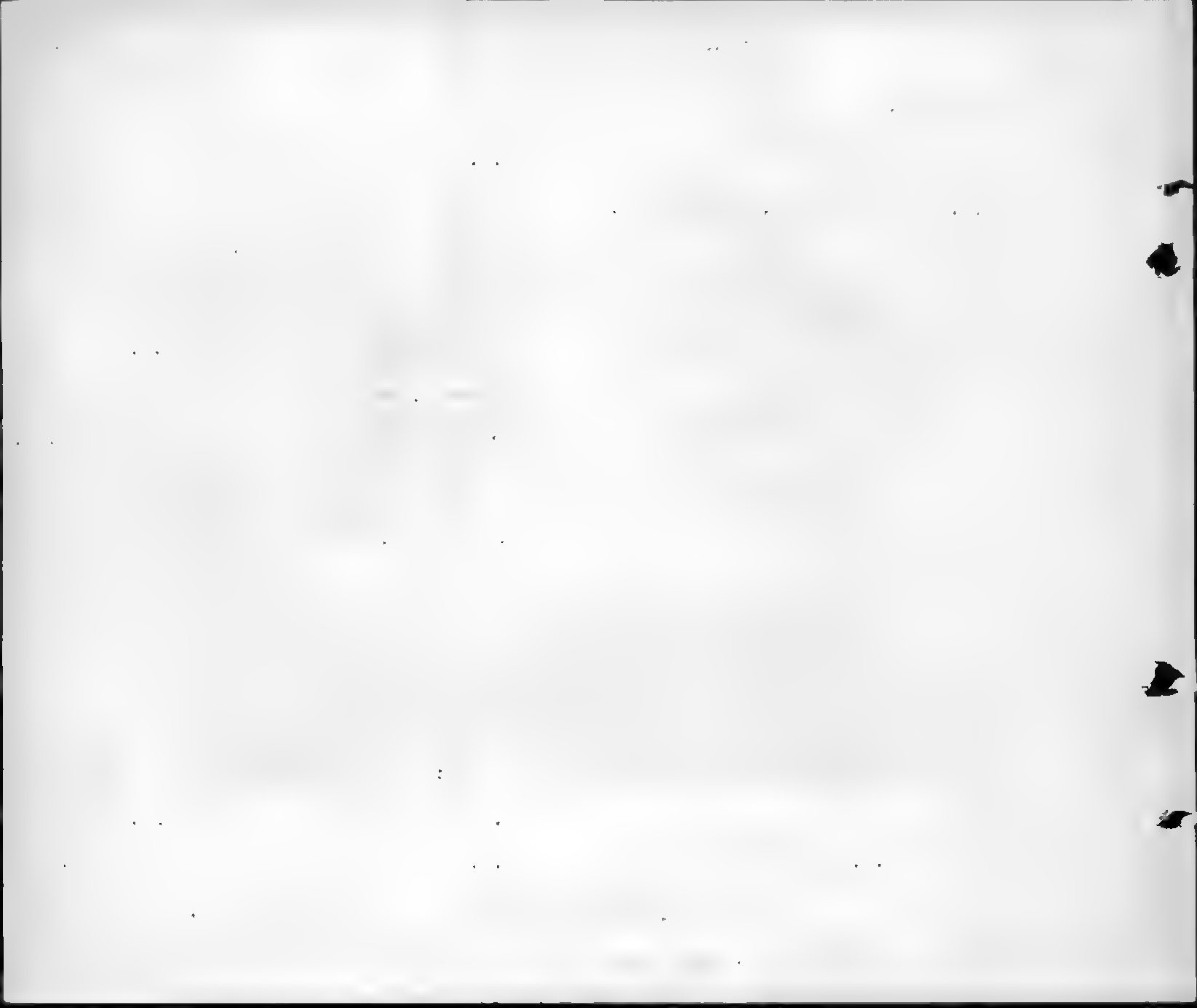
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Cd		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 1 day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. Naval Station Hospital		
f. STREET ADDRESS Patuxent River Maryland			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last VIGIL			4. DATE OF DEATH Month February Day 26 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-60		9. AGE (In years last birthday) yrs 14 Months 14 Days 14 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Joe Vigil			14. MOTHER'S MAIDEN NAME Linda M. JOHNS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		INFORMANT Joe Vigil Address (Father) Hills Traylor Court, Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) peritonitis and bowel gangrene 560.2 DUE TO (b) ruptured congenital omphalocele Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 12-hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Prematurity INTERVAL BETWEEN ONSET AND DEATH 4 hrs					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 25 February, 1960 to 26 February, 1960 , that I last saw the deceased alive on 26 February, 1960 , and that death occurred at 6:47A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. 2- -60 DATE SIGNED 26 February, 1960					
ACTUAL SIGNATURE G.B. Avery		M.D. U.S. Naval Hospital, Bethesda Md. 2- -60			
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN		U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/60		22c. NAME OF CEMETERY OR CREMATORY ST.ALOYSIOUS CEMETERY	
22d. LOCATION (City, town, or county) (State) Leonardtwn, Md.		22e. REC'D BY REGISTRAR MAR 2 '60		22f. REGISTRAR'S SIGNATURE Arthur S. Kline	
23. FUNERAL DIRECTOR'S SIGNATURE Mattingley Senwick St. Leonardtown Maryland					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2181 CERTIFICATE OF DEATH

02279

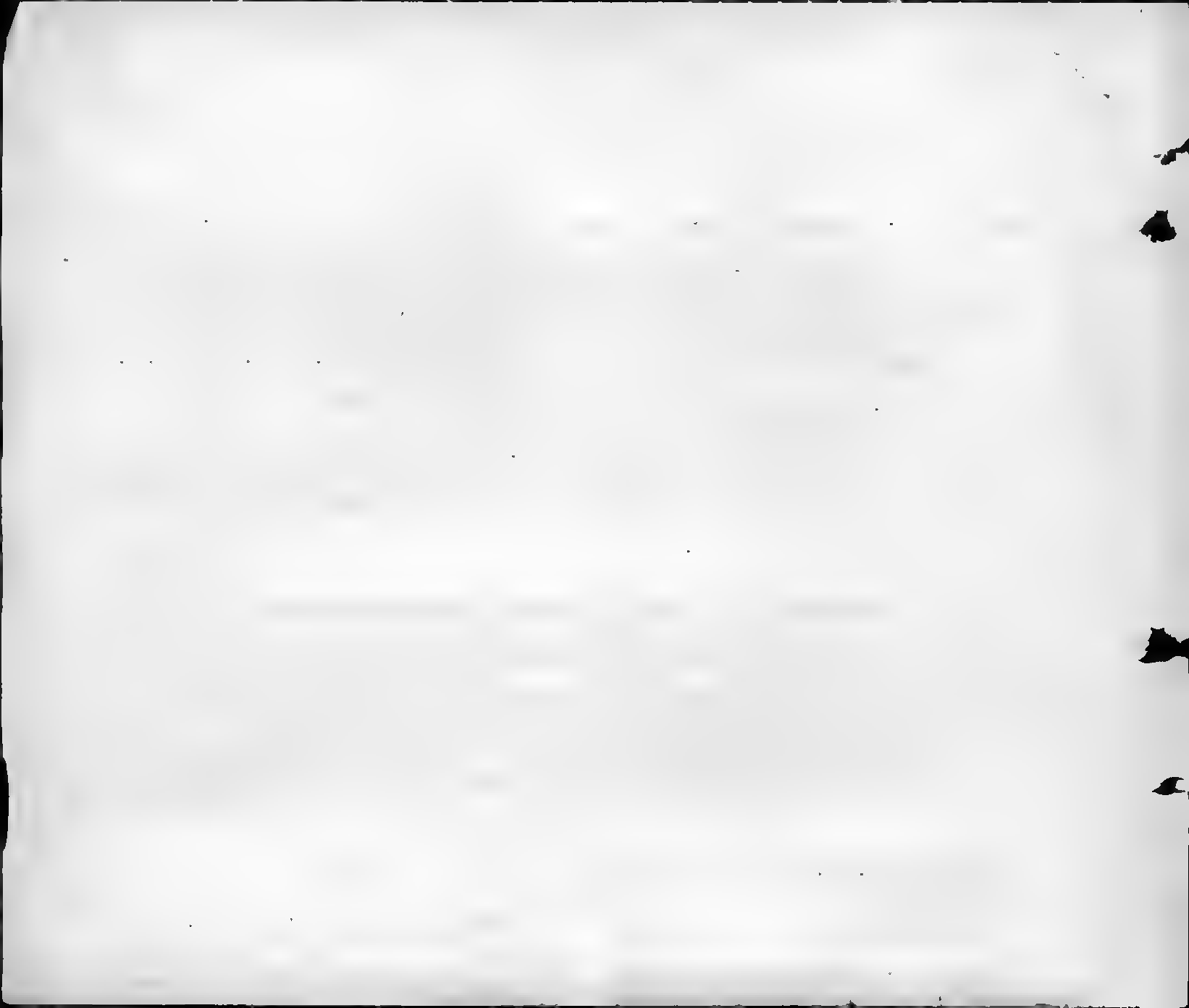
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 E. Jefferson St.,		d. STREET ADDRESS 101 East Jefferson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANNIE S. VINSON		4. DATE OF DEATH Month February Day 12 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1868
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Montgomery Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Vinson		14. MOTHER'S MAIDEN NAME Rachael Prout	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Albert Bouic, Rockville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage - Right hemisphere 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1928 19 Feb 12 , 19 60 , that I last saw the deceased alive on Feb 11 , 19 60 , and that death occurred at 9:30 A. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 110 S. Washington St. Rockville, Md.	
ACTUAL SIGNATURE Wm. A. Linthicum M.D.		DATE SIGNED 2/12/60	
PHYSICIAN'S NAME (Type) Wm. A. Linthicum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/15/60	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Rockville, Maryland		24a. REC'D BY REGISTRAR DATE FEB 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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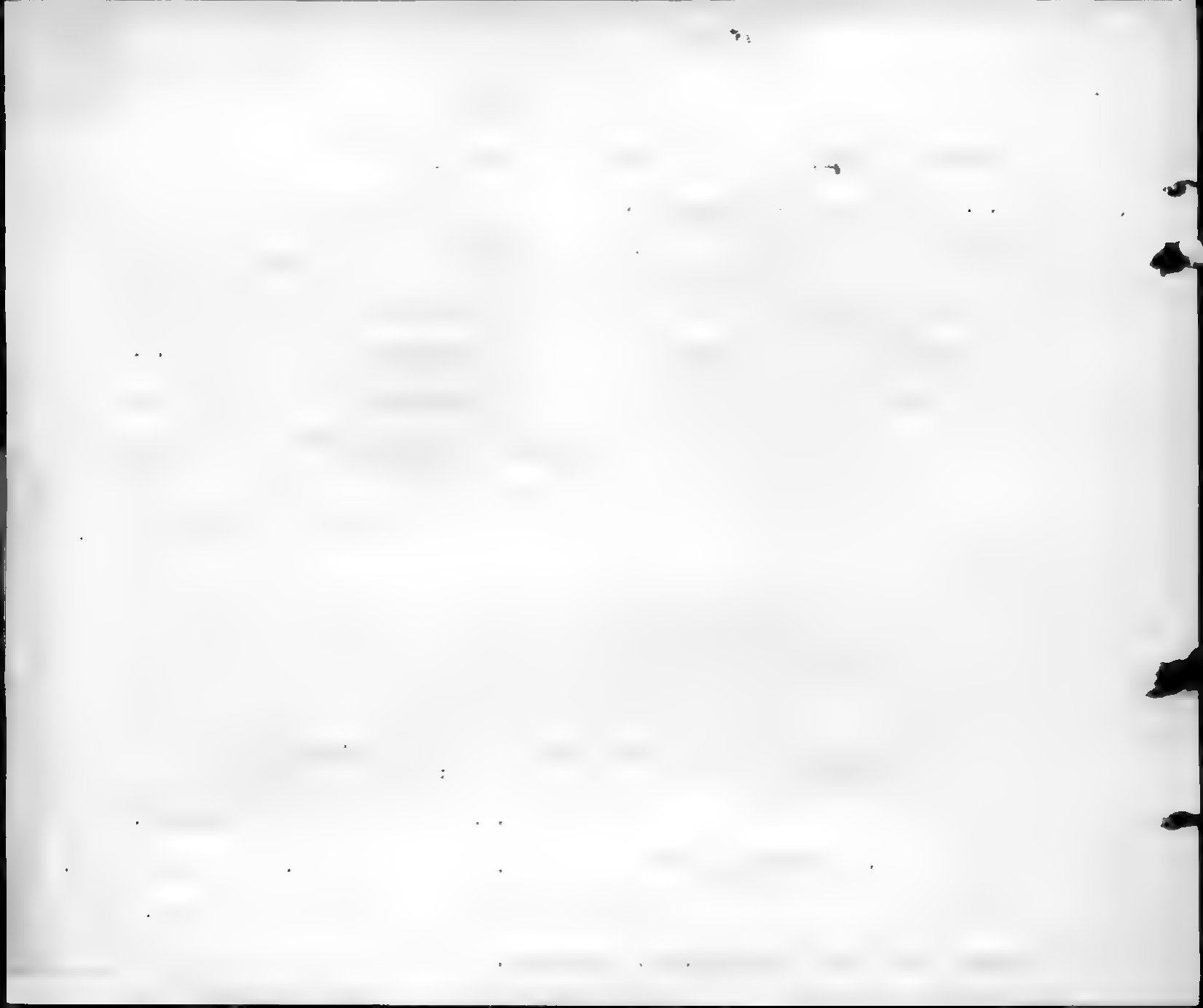


CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Bethesda			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN TB 97 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 7905 Chelton Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ella Middle Marie Last WALKER				4. DATE OF DEATH Month February Day 24 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-3-91	
9. AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min 60		IF UNDER 24 HRS Months 24 Days 24 Hours 19 Min 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John ELLIS				14. MOTHER'S MAIDEN NAME Susan KELLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO (Daughter) Mildred SCHER			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191.5 DUE TO Carcinoma of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma DUE TO 2 yrs (c) 7 years				INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 November 1959 to 24 February 1960 , that I last saw the deceased alive on 24 February 1960 , and that death occurred at 2:40 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. U. Bramlett				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 2-25-60			
PHYSICIAN'S NAME (Type) C. U. BRAMLETT LT MC USN				U.S. Naval Hospital, NMMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-29-60			
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery				22d. LOCATION (City, town, or county) (State) Philadelphia Penn.			
23. FUNERAL DIRECTOR'S SIGNATURE Nally 3200 Rhode Island Ave. Mt. Ranier, Md.				24a. REC'D BY REGISTRAR DATE FEB 29 '60			
24b. REGISTRAR'S SIGNATURE C. L. L. L.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2130

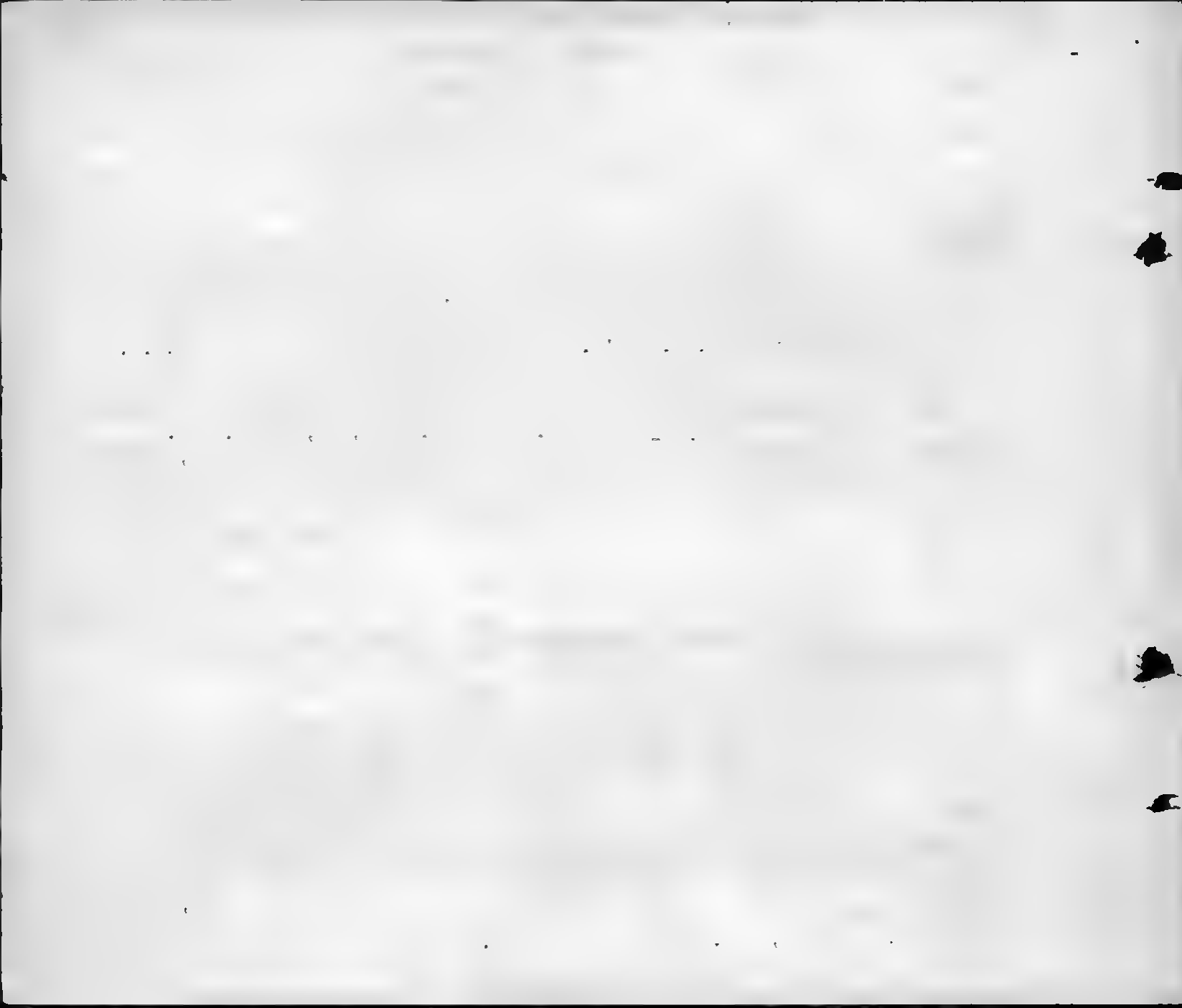
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 week	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 2106 Hildarose Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3126 Helsel Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last FRANCES MARY WALL		4. DATE OF DEATH Month Day Year FEBRUARY 12 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 16, 1897
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH FOLK		14. MOTHER'S MAIDEN NAME ELLA BROOM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 210-12-1541	
17. INFORMANT Mr. Donald R. Wall, 13,304 Ga. Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST WITH METASTASES DUE TO (c) HYPERTENSIVE VASCULAR DISEASE SILVER SPRING, MARYLAND INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 5 YEARS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE VASCULAR DISEASE		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SILVER SPRING		(County) (State)	
21. I certify that I attended the deceased from MAY, 1935, to FEB 12, 1960, that I last saw the deceased alive on FEB 12, 1960, and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7733 ALASKA AVE NW FEB 12 1960 WASH DC			
ACTUAL SIGNATURE ROBERT L. KRICHMAR M.D.		PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/15/60	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ROBERT L. KRICHMAR		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE FEB 16 '60
24b. REGISTRAR'S SIGNATURE Curtis S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2295

CERTIFICATE OF DEATH

02282

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 Hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
f. STREET ADDRESS <u>3410 38th St. N.W.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>M.</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/80</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Florida Hackett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
INFORMANT <u>Niece (Mrs. Katherine Sterling)</u>		Address <u>Same as Above</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u>			
443X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause as (b) <u>Arteriosclerotic cerebral vascular disease</u>			
(c) <u>Hypertensive cardiovascular disease</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Feb 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>60</u> , and that death occurred at <u>10:22</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Robert Young</u>		M.D. <u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2-10-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2131

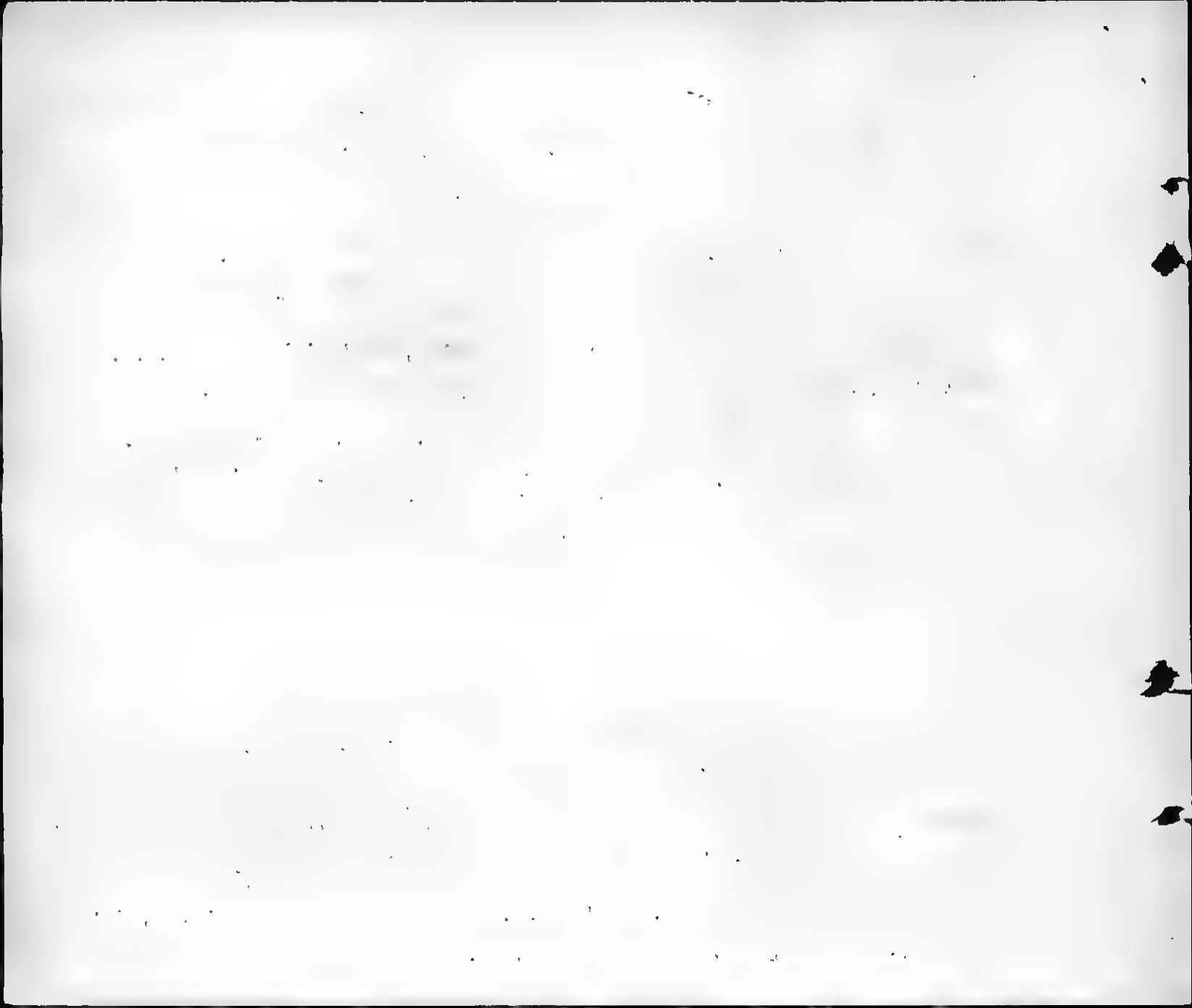
Item 8 Film 0256 2-10-55 et

CERTIFICATE OF DEATH

02283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm'ssion) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b since 12/5/59	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7719 EASTERN AVENUE		e. STREET ADDRESS 7719 EASTERN AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last MARION MARTHA WATTS		4. DATE OF DEATH Month Day Year FEB. 5 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1869 AGE (In years last birthday) 90 yrs IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES W. WATTS		14. MOTHER'S MAIDEN NAME REBECCA M. GOODWIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. INFORMANT Address Miss Alice C. Watts, 7719 Eastern Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4:00.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Maryland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to 5 Feb , 1960 that I last saw the deceased alive on 4 Feb , 1960, and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9006 Columbia Rd, Silver Spring, Md DATE SIGNED 2/5/60			
ACTUAL SIGNATURE William D. Aud M.D.		PHYSICIAN'S NAME (Type) WILLIAM D. AUD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/60	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATH. CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 2296 b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5006 Edgemoor Lane</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5006 Edgemoor Lane</u></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Mary Rachael S. Webner</u> 4. DATE OF DEATH <u>Feb 16 1960</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>5. SEX <u>female</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>9-6-1867</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years last birthday) <u>92</u> yrs.</p>	<p>11. BIRTHPLACE (State or foreign country) <u>Del.</u></p>
<p>12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u></p>		<p>13. FATHER'S NAME <u>William Simpson</u></p>	
<p>14. MOTHER'S MAIDEN NAME <u>W. Gordon</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p>	
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>W. Gordon Webner</u> Address <u>Fluor 2</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. DUE TO (c)</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>year</u></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>	<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	<p>20f. (City or town) (County) (State)</p>
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <u>Frank J. Broschant</u></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u></p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>22a. FUNERAL, CREMATION, or BURIAL (Specify)</p>		<p>22b. DATE THEREOF <u>2/16/60</u></p>	
<p>22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u></p>		<p>22d. LOCATION (City, town, or country) (State) <u>300-4th St. N.E. Wash. D.C.</u></p>	
<p>23. FUNERAL DIRECTOR ADDRESS <u>J. William Lee's Sons Co. 300-4th St. N.E. Wash. D.C.</u></p>		<p>24a. REC'D BY REGISTRAR <u>FEB 18 '60</u></p>	
<p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u></p>		<p>DATE SIGNED <u>2-16-60</u></p>	

MEDICAL CERTIFICATION

2

8284



2297

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 24 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
f. STREET ADDRESS 1026 N. Madison Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
						WELSH	
4. DATE OF DEATH		Month		Day		Year	
		February		3		19 60	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-3-60			Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		- - - - -		Maryland		USA	
13. FATHER'S NAME John F. WELSH				14. MOTHER'S MAIDEN NAME Margaret Ann VENEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT		Address	
No		None		Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrops fetalis							
770.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							
(b) Erythroblastosis fetalis							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from February 2, 19 60 to February 3, 19 60 , that I last saw the deceased alive on February 3, 19 60 , and that death occurred at 1:33 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. W. GRELLO -				ADDRESS (Street, city or town, state) U. S. Naval Hospital			
DATE SIGNED 2-4-60							
PHYSICIAN'S NAME (Type) F. W. GRELLO, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2/9/60		Arlington National		Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Heanson's Funeral Home Falls Church Va.				24a. REC'D BY REGISTRAR FEB 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



2298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp.		e. STREET ADDRESS 209 King William Drive	
3. NAME OF DECEASED (Type or print) First JAMES Middle WILSON Last WHITE		4. DATE OF DEATH Month 2. Day 6 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.9.1886
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Alexander White		14. MOTHER'S MAIDEN NAME Jenny S. Smiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 216-22-1409 INFORMANT Hospital records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 8 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 59 to 2-6 , 19 60 and that death occurred at 2:15 PM , from the causes and on the date stated above. olive on 2-6 , 19 60 , and that death occurred at 2:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg Md. DATE SIGNED 2-6-60			
ACTUAL SIGNATURE Dr. Jack Schumacher			
PHYSICIAN'S NAME (Type) Dr. Jack Schumacher			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	2/8/60	Darnestown Church Cem.	Darnestown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		ADDRESS 1331 E. Monte	24a. REC'D BY REGISTRAR FEB 9 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2299

CERTIFICATE OF DEATH

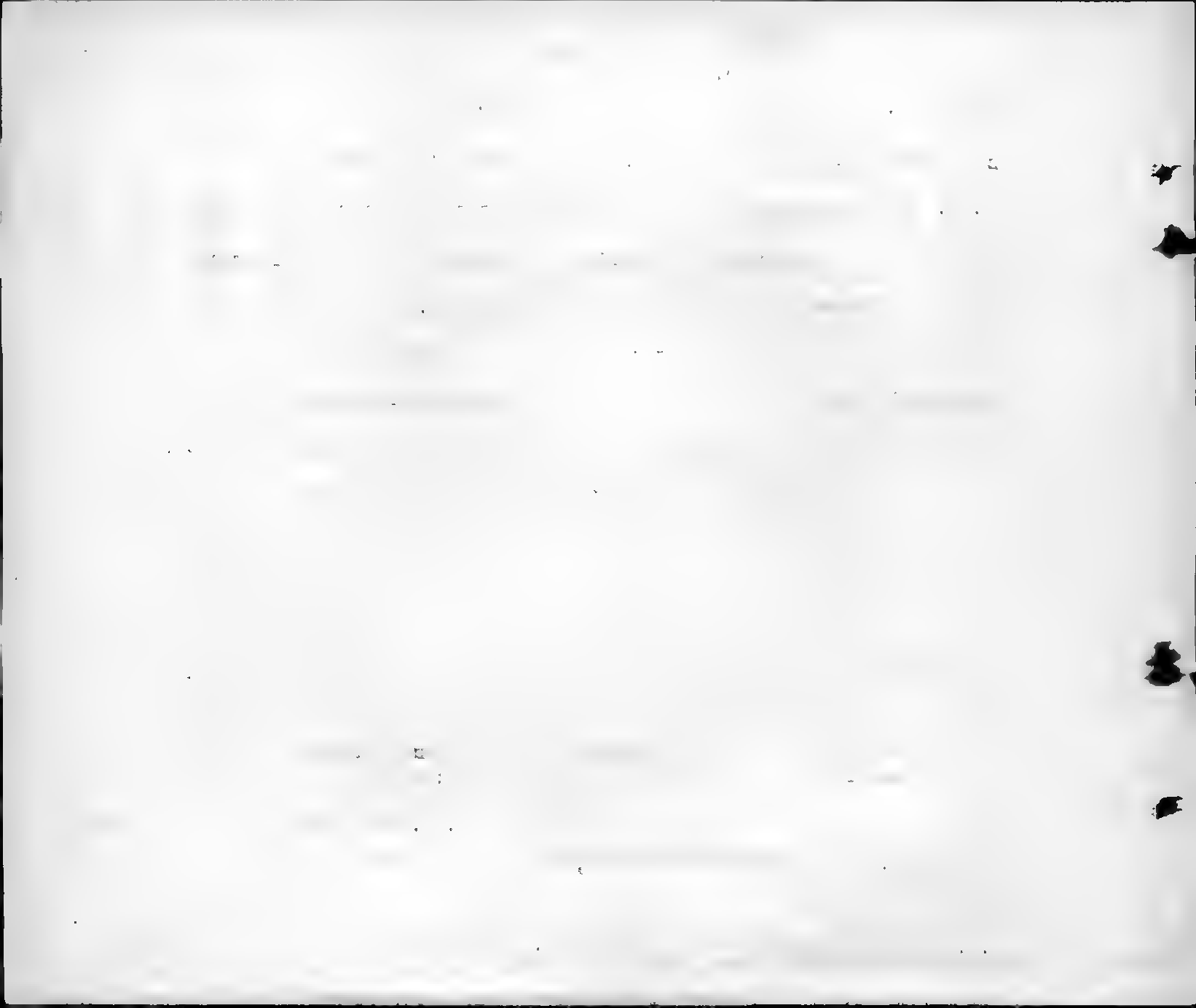
Reg. Dist. No. 215

112287

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Town Creek California c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Town Creek California d. STREET ADDRESS - - - - - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Marie WHITE				4. DATE OF DEATH Month Day Year February 3 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-53	
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John David WHITE				14. MOTHER'S MAIDEN NAME Lelia Marie GIBSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Address (F) John D. White, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Transposition of Great Vessels) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from January 31 , 19 60 to February 3 19 60 , that I last saw the deceased alive on February 3 , 19 60 , and that death occurred at 4:43 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2-4-60							
ACTUAL SIGNATURE J. E. MC CLENATHAN M.D.				PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-6-60		22c. NAME OF CEMETERY OR CREMATORY Monticello Memorial	
22d. LOCATION (City, town, or county) Charlottesville				(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				24a. REC'D BY REGISTRAR FEB 8 '60		24b. REGISTRAR'S SIGNATURE Colman L. Traub	
23. FUNERAL DIRECTOR'S ADDRESS Hill & Irving Funeral Home, Bethesda, Md. for				24b. REGISTRAR'S ADDRESS Hill & Irving Funeral Home, Charlottesville, Va.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2132 CERTIFICATE OF DEATH

02288

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB apprx. 12 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 9026 FAIRVIEW ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9026 FAIRVIEW ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSIE Middle (NMI) Last WILLIAMSON		4. DATE OF DEATH Month FEBRUARY 14 Day 19 Year 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 2, 1868
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) FRIENDLY, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT WILLIAMSON		14. MOTHER'S MAIDEN NAME REBECCA ELLIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. ESTHELENE MORGAN, 9026 FAIRVIEW RD., SILVER		Address SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma Pancreas DUE TO (b) 6 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1956 to Feb 14, 1960 that I last saw the deceased alive on Feb 14, 1960 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Curry M.D.		ADDRESS (Street, city or town, state) 10620 Georgia Ave 2/14/60	
PHYSICIAN'S NAME (Type) JOHN J. CURRY		DATE SIGNED Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 17, 1960	
22c. NAME OF CEMETERY OR CREMATORY ZION HILL CEMETERY		22d. LOCATION (City, town, or county) (State) TYLER COUNTY, WEST VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. POMPHREY, INC., SILVER SPRING, MD. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE FEB 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



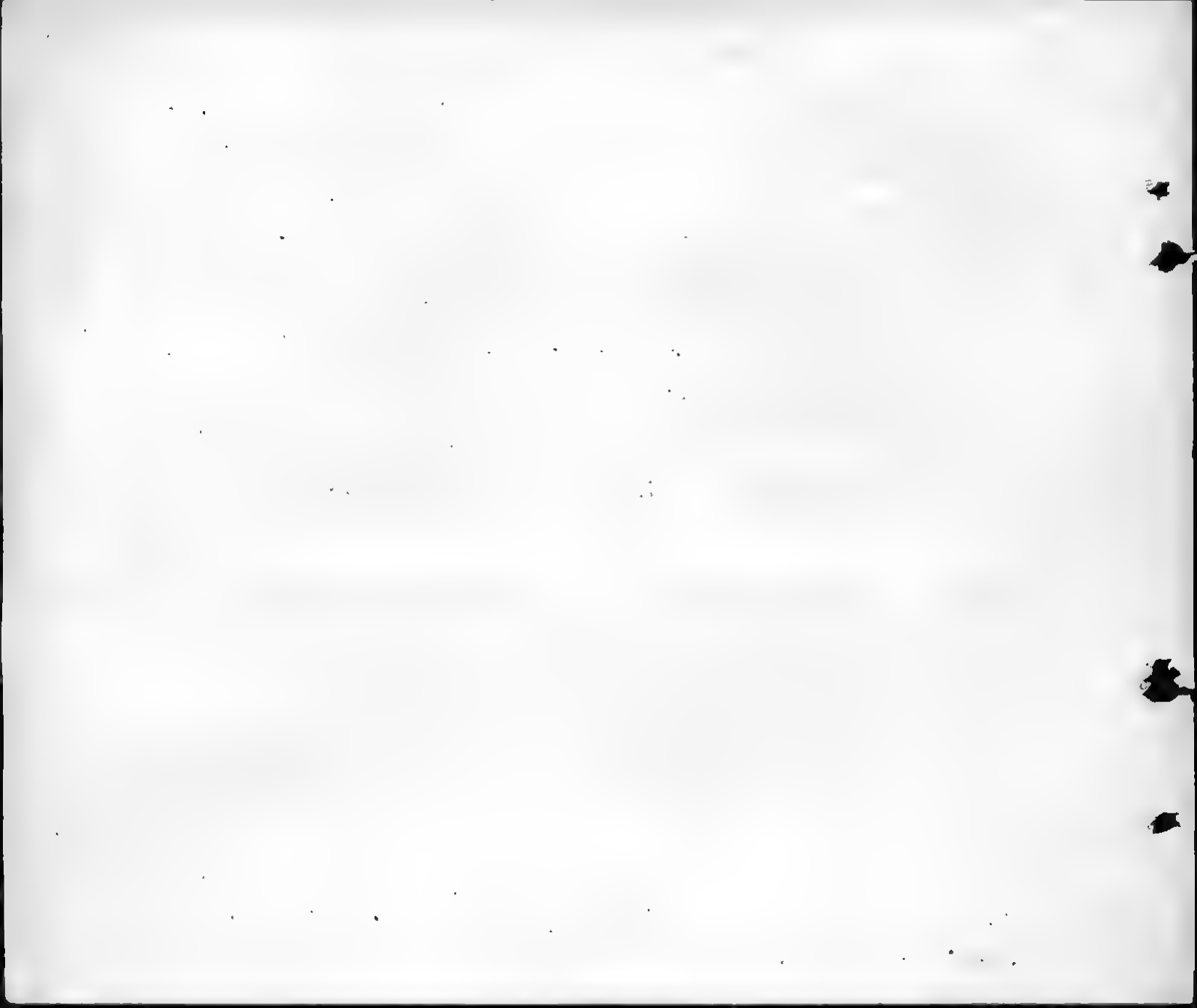
2161

CERTIFICATE OF DEATH

Reg. Dist. No.

1
M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
		d. STREET ADDRESS 1021-QUEBEC TERR.	
3. NAME OF DECEASED (Type or print) IRVING - WOLF		4. DATE OF DEATH FEB-7-1960	
5. SEX MALE	6. COLOR OF RACE WH.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KEY		10b. KIND OF BUSINESS OR INDUSTRY GROCE	
11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BERNARD WOLKOVITCH		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 098-10-9296	
17. ADDRESS 1021-QUEBEC TERR. SPR.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 241X DUE TO BRONCHIAL CESTHMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) EMPHYSEMA DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 1, 1960 to FEB 7, 1960 that I last saw the deceased alive on FEB 6, 1960 and that death occurred at 1515 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Boris Rabin		ADDRESS (Street, city or town, state) 1019 University Ave. N.W. 2/7/60	
PHYSICIAN'S NAME (Type) BORIS RABIKIN		SIGNATURE Sylvia S. Rabin	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2/9/60	22c. NAME OF CEMETERY OR CREMATORY NAT'L MEM PARK	22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		ADDRESS 4217-92ND AVE	
24a. REC'D BY REGISTRAR DATE FEB 9 '60		24b. REGISTRAR'S SIGNATURE Orlando J. Hanna	



2162

CERTIFICATE OF DEATH

Reg. Dist. No.

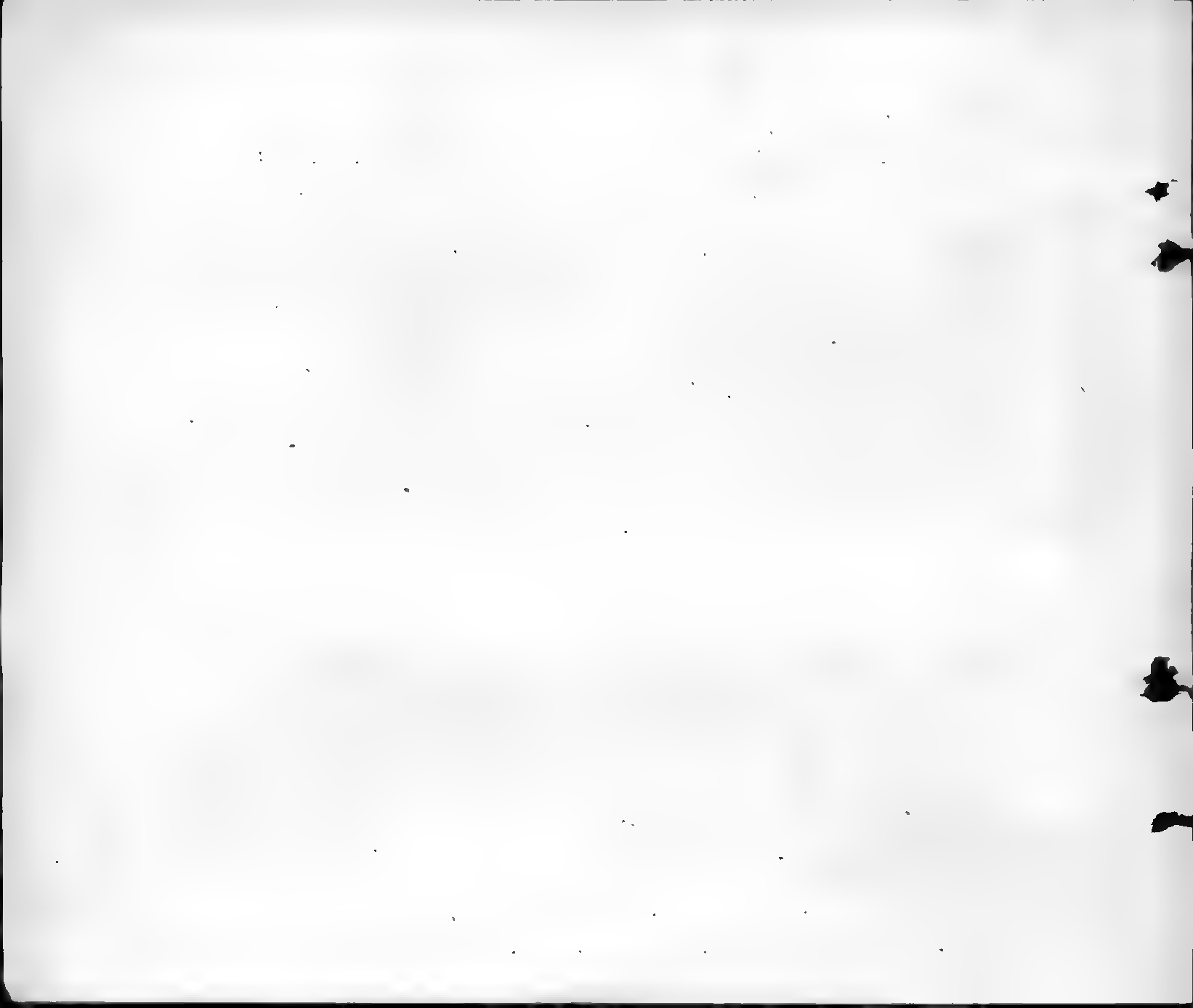
02290

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on: Res.dence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>WASHINGTON DC</u> ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY IN 1b <u>4 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>117 ALBANY AVE</u>		d. STREET ADDRESS <u>632 JEFFERSON NW</u>	
3 NAME OF DECEASED (Type or print) <u>JENNIE</u> First <u>WOLF</u> Middle <u>-</u> Last		4. DATE OF DEATH <u>FEB-16-</u> Month <u>1960</u> Day <u>16</u> Year	
5. SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2</u> <u>76</u> yrs.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>ELI HOROWITZ</u>	
14 MOTHER'S MAIDEN NAME <u>RUTH LEE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>578-20-0093</u>		17. INFORMANT <u>LOUIS WOLF</u> Address <u>632 Jefferson NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Hypertensive Ht. Dis</u> DUE TO (c) <u>yo</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE COND.T ON GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>41</u> , to <u>Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>60</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Isidor Shulman</u> M.D.		ADDRESS (Street, city or town, state) <u>915-19th St. NW</u> DATE SIGNED <u>Feb. 1960</u>	
PHYSICIAN'S NAME (Type) <u>ISIDORE SHULMAN</u>		<u>Wash. D. C.</u>	
22a BURIAL, CREMATON, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>2/18/60</u>	<u>OHIV SHOLOM Cem</u>	<u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herman Shulman</u> ADDRESS <u>4217 9th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12291

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) • STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2414 EVANS DRIVE		d. STREET ADDRESS 2414 EVANS DRIVE	
3. NAME OF DECEASED (Type or print) RICHARD A. WOLF		4. DATE OF DEATH Month FEBRUARY Day 29 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 30, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair man, Central office		11. BIRTHPLACE (State or foreign country) PENNA.	
13. FATHER'S NAME ADAM ELMER WOLF		14. MOTHER'S MAIDEN NAME MINNIE MAE GLASS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW #2		16. SOCIAL SECURITY NO. 166-12-6172	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		DATE SIGNED FEB. 29, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 3/2/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY YORK, PENNSYLVANIA		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Charles S. Huns	



2163 CERTIFICATE OF DEATH

02292

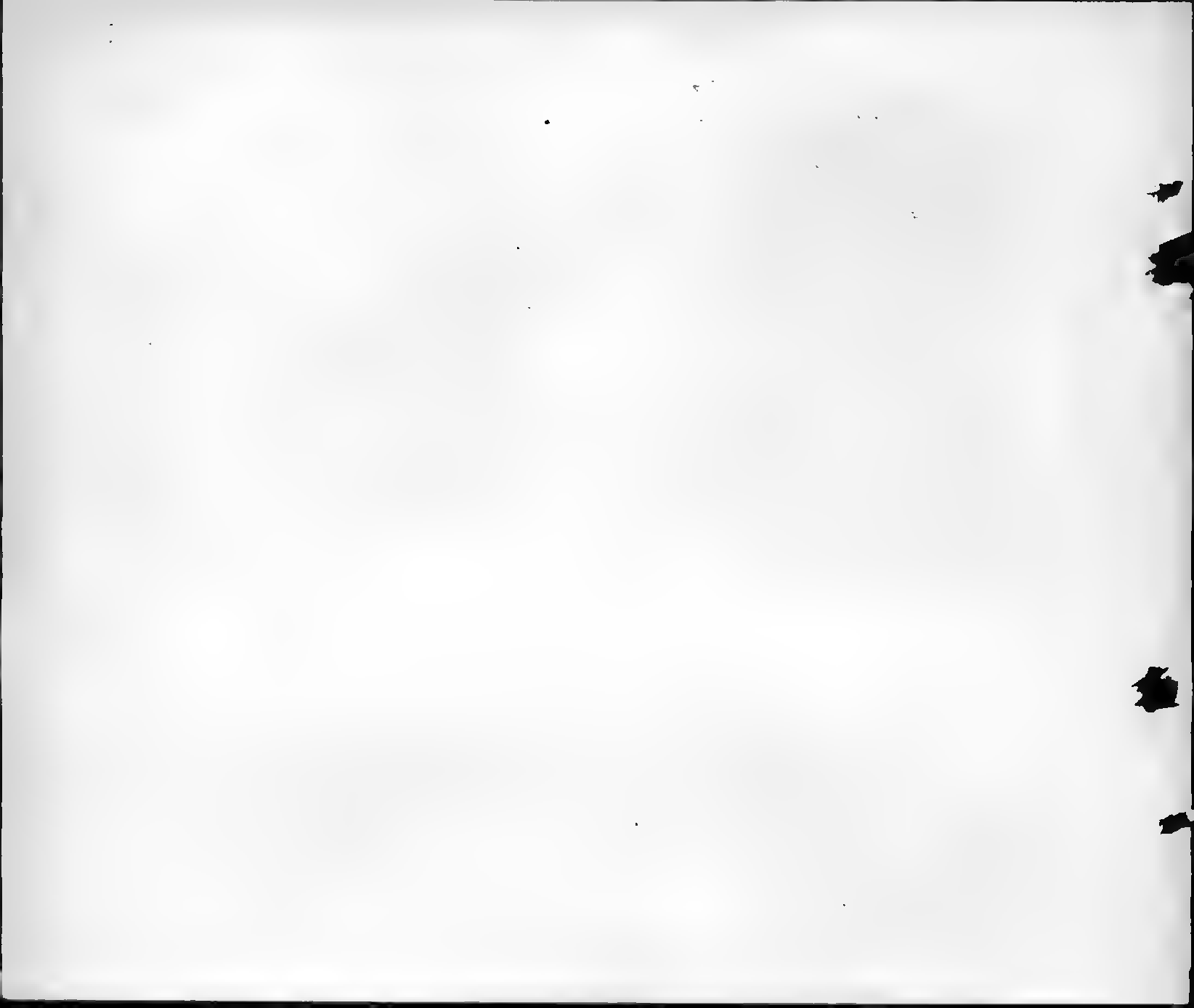
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN TB <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. STREET ADDRESS <i>10523 Deakins Hall Drive</i>	
3. NAME OF DECEASED (Type or print) First <i>Sydney</i> Middle <i>Lynette</i> Last <i>Wolman</i>		4. DATE OF DEATH Month <i>2</i> Day <i>5</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-13-59</i>
9. AGE (In years lost birthday) yrs <i>1</i> 33		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>33</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>-</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland/Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin R. Wolman</i>		14. MOTHER'S MAIDEN NAME <i>Mary L. Laurentitz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Father</i>		Address <i>- same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchio/itis -</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>-</i> DUE TO (c) <i>-</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Congenital Heart Disease. Type - Undet.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/13</i> 19 <i>59</i> to <i>2/5</i> 19 <i>60</i> , that I last saw the deceased alive on <i>2/5</i> 19 <i>60</i> , and that death occurred at <i>7:30</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph Stiller</i> M.D.		ADDRESS (Street, city or town, state) <i>931 Pershing Drive -</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Ralph Stiller</i> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2-7-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i> ADDRESS <i>2100 Cotton Place</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

24227 XV3



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

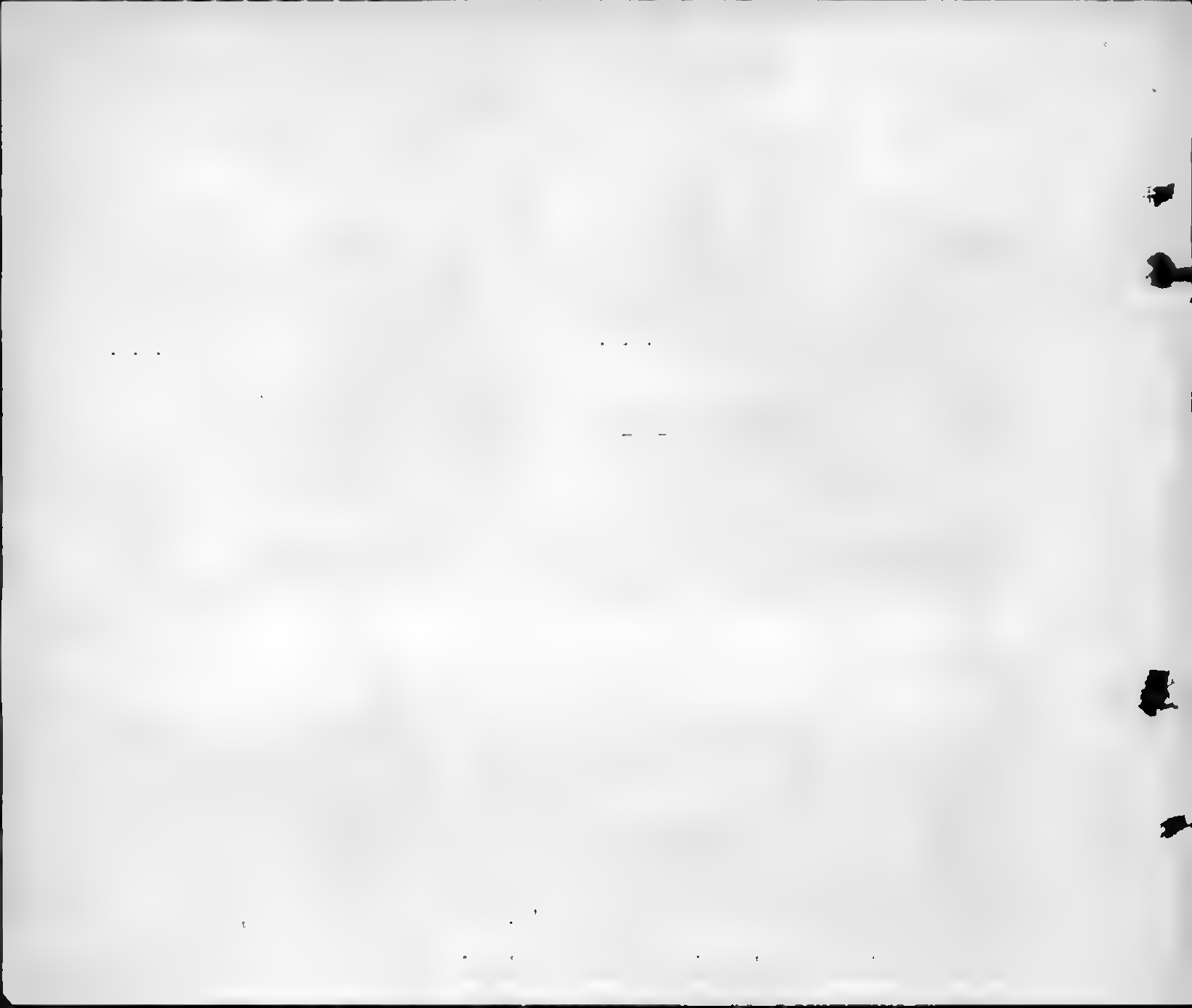
Reg. Dist. No.

02293

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK.</u>		c. LENGTH OF STAY IN 1b. <u>25 HOURS 15 MIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>3410 Embury St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>ROSSELL</u> Last <u>WOODRING</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-17</u>
9. AGE (in years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.I.H.</u>	11. BIRTHPLACE (State or foreign country) <u>MINN.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Sonheim</u>	
14. MOTHER'S MAIDEN NAME <u>Ida Rosen CORNELIA WEEKS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>469-07-0354</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>116.0</u> Conditions, if any, which gave rise to immediate cause (b) <u>1st 2nd + 3rd degree burn involving</u> (c) <u>2/3 of body & extremities</u> DUE TO <u>2/3 of body & extremities</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Burned at home due to house fire</u>		20c. TIME OF INJURY Month, Day, Year <u>2-10-1960</u> Hour <u>7</u> a.m. <u>P.M.</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Wheaton</u>		(County) <u>Montg.</u>	
(State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PIMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>Feb 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Paul J. Hume</u>		24c. REGISTRAR'S SIGNATURE <u>Paul J. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1113. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

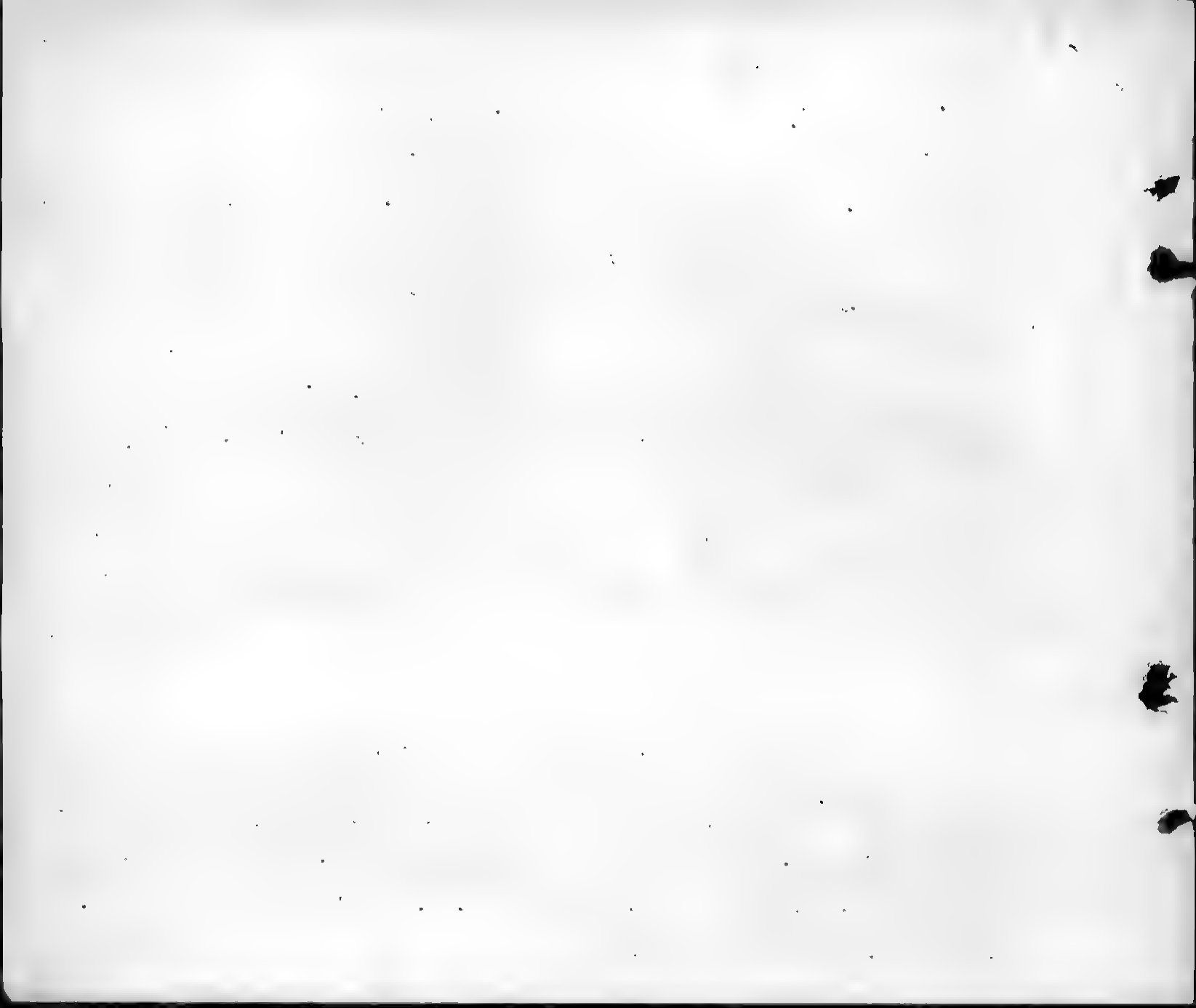
02294

2300

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>11 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>6216 GREENTREE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>INRIGHT</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1884</u>	
9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL DYE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>DAVID HENRY WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>TEN BROECK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>1 DAY-</u>				16. SOCIAL SECURITY NO. <u>183-103-6583A</u>			
INFORMANT <u>MRS. H. A. McGRATH</u>				Address <u>6216 GREENTREE RD. BETHESDA, Md.</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY OCCLUSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 5 YRS							
(c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> 5 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>NOV. 17</u> , 19 <u>59</u> , to <u>FEB 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 7</u> , 19 <u>60</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u>				ADDRESS (Street, city or town, state) <u>M.D. 5009 DEL RAY AVE., BETHESDA, MD.</u> DATE SIGNED <u>2/8/60</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				5009 DelRay Ave. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Bur-transit</u>		<u>2/10/60</u>		<u>Holy Sepulchre Cem.</u>		<u>Philadelphia, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2134
CERTIFICATE OF DEATH

Reg. Dist. No.

02295

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2023 LANIER DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ABBIE</u> Middle <u>G.</u> Last <u>YOCUM</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u> Hours <u>19</u> Min.	11. IF UNDER 74 HRS. Months <u>2</u> Days <u>5</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SHAMOKIN, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LYBRAND HUFMAN</u>		14. MOTHER'S MAIDEN NAME <u>ISABEL POWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Cora Y. Duhn, 2023 Lanier Dr.</u>		Address <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 20, 1960</u> to <u>Feb. 25, 1960</u> , that I last saw the deceased alive on <u>Feb. 25, 1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Little</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6911 5th St. NW Wash. 12, DC</u>	
PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FOREST OAK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>GAITHERSBURG, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Fumfurey, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

[Faint, mostly illegible text on a lined form, likely containing fields for name, date, and cause of death.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2301

CERTIFICATE OF DEATH

Reg. Dist. No.

02296

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 9108 Louis Avenue	
3. NAME OF DECEASED (Type or print) LEO First XXXXXX Middle F. Last Zwischen				4. DATE OF DEATH February 6, 1960		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1874	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR 5 months 23 days		11. IF UNDER 24 HRS. 23 hours 5 min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Potomac Elec.		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Johanna O-Dekoon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. Yes		17. INFORMANT Daughter 4847 Adeland Street Mrs. Geo. Goetzman- Chevy Chase, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus (c) Diabetes mellitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 18, 1959 to Feb 6, 1960 , that I last saw the deceased alive on January 14, 1960 , and that death occurred at 7:52 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1019 University Boulevard E. Silver Spring, Maryland DATE SIGNED 2/6/60							
ACTUAL SIGNATURE Boris Rabin M.D.				PHYSICIAN'S NAME (Type) BORIS RABKIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-9-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Suitland, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland			
24a. REC'D BY REGISTRAR FEB 9 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

MASSACHUSETTS DEPARTMENT OF HEALTH

Name of Deceased		Age		Sex		Color	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Date of Death	
123 Main St, Boston		Teacher		Heart Disease		Jan 15, 1901	
Place of Death		Physician		Burial Place		Buried	
Home		Dr. Smith		Cemetery		Yes	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Issued by		Reviewed by		Approved by	
Jan 16, 1901		[Signature]		[Signature]		[Signature]	